

CBT for the Treatment of Anxiety of a Non-Traditional Male College Student

An Empirically Supported Treatment Case Study
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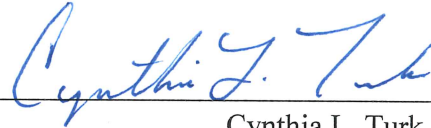
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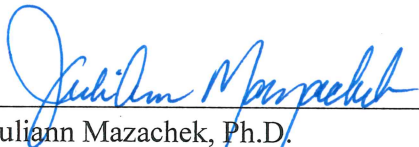
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CBT FOR THE TREATMENT OF ANXIETY OF A NON-TRADITIONAL MALE
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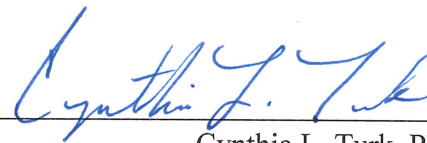
MASTER OF ARTS DEGREE



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Abstract

The following case study discusses the treatment process and outcome for David, a Caucasian 37-year-old non-traditional humanities college student residing in a midsize city in Midwest America. David was seen at a university counseling center one year before graduating. David presented with severe anxiety symptoms that affected his cognitions, emotions, physiological symptoms, behaviors, and his overall functioning. David reported these symptoms led to impairment in his social and leisure life. This clinician employed Cognitive Behavioral Therapy (CBT) to assist David in learning skills to effectively manage and reduce his anxiety symptoms. The interventions utilized include psychoeducation, relaxation training, and cognitive restructuring. This case study reviews the initial interview, process of diagnosis, utilization of assessments, the treatment plan, the implementation of the treatment interventions, and the barriers to treatment. A transcription of one session is provided in order to provide a glimpse of David's presentation in session and the clinician's approach to treatment.

Theoretical Foundation of Generalized Anxiety Disorder and Social Anxiety Disorder

Etiology

Triple vulnerability theory. The triple vulnerability theory (TVT), which is a version of the more generic diathesis-stress model, suggests that several vulnerabilities must be in place before the development of an anxiety disorder and that these vulnerabilities interact for specific emotional disorders to develop (Barlow, 2002). Adverse early experiences create psychological vulnerabilities that interact with a genetic vulnerability. These vulnerabilities are activated when the individual experiences additional stressful events later in life, leading to the development of an anxiety or depressive disorder (Gillespie & Nemeroff, 2007; Heim, Owens & Levine, 2005; Plotsky, & Nemeroff, 1997).

According to this model, the generalized biological vulnerability consists of genetic contributions (heredity) to the development of anxiety and negative affect. Some individuals may inherit a tendency to be anxious or emotional. Said differently, some people may have a predisposition to be biologically reactive to stressors and novelty in the environment. These individuals may not only be temperamentally anxious (frequently preparing for danger) but also have a lower threshold for a fight-or-flight reaction (Barlow, 2002; Hettema, Prescott, Myers, Neale, & Kendler, 2005). The general biological vulnerability encompasses research on temperament with varying labels including “neuroticism,” “negative affect,” “behavioral inhibition,” or “trait anxiety” (Barlow, 2002).

The TVT posits biological vulnerability is only expressed when psychological vulnerabilities are also present. The generalized psychological vulnerability is characterized by the perception that important environmental events are unpredictable and uncontrollable (i.e.,

diminished sense of control) (Barlow, 2000, 2002). This generalized psychological vulnerability encompasses a pessimistic attributional style. Individuals with a pessimistic attributional style attribute negative events to internal, global, and stable causes and positive events to external, unstable and specific causes (Abramson, Seligman, & Teasdale, 1978). The individual's perceived lack of control in response to these challenges exacerbates the vulnerability to the experience of negative emotional states (McCauley, Mitchell, Burke, & Moss, 1988; Skinner, Chapman, Baltes, 1988; White, Brown, Somers, & Barlow, 2006).

A generalized psychological vulnerability develops when an individual has early negative or even traumatic developmental experiences and/or a lack of access to predictable care and nurturing from caregivers. The characteristics of the family and parenting styles have been shown to be linked to the development of a sense of control (Schneewind, 1995). Parenting styles that influence the development of a sense of control in children are warmth/sensitivity, consistency and contingency, as well as encouragement of autonomy and absence of intrusion or of an over-controlling style (Barlow, 2002; Chorpita, 2001). Over time, these experiences become a part of the individual's stored (learned) information and influence the individual to have a generalized sense of control.

TVT further suggests specific psychological vulnerability must exist along with the generalized biological and psychological vulnerabilities in order for a specific clinical disorder to develop. Barlow (2002) argued specific psychological vulnerability is developed by learning through early experiences or observation that a specific feature, internal sensation, or situation is dangerous and that there are different ways an individual can develop a specific psychological vulnerability. One way could be through direct involvement in a situation that results in real danger or pain. For example, a person might learn that social situations are dangerous after

being bullied. Another way could be through experiencing a false alarm (panic attack) in a specific situation. For example, a person might become fearful of air travel after having a panic attack on an airplane. An individual can also develop a specific psychological vulnerability by witnessing or being told that a situation is dangerous. For example, a person who has witnessed or learned about a parent having a heart attack might become fearful of bodily sensations like shortness of breath or tightness in the chest. The TVT states that first, all of the three vulnerabilities need to be present in order for an individual to develop a disorder, and second a stress inducing event or experience must be present to activate such vulnerabilities (Barlow, 2002). For example, with panic disorder, the individual may have all of the vulnerabilities, but a respiratory disease that the individual developed could have activated these vulnerabilities and the individual may then develop a fear of panic attacks, hence developing panic disorder.

Cognitive Theory. Beck's cognitive theory emphasizes the important role of cognitions in determining feelings (e.g., anxiety) and behavior (Beck, 1967). These cognitions include a person's thoughts, beliefs and perceptions with cognitive schemas and affect are closely joined. According to Beck, emotional problems arise when distorted thinking patterns influence our interpretation of environmental events. He states that our behavior is not really determined by what is actually happening in the environment; instead, our behavior is determined by our thoughts about what is happening. Therefore, behavior is significantly influenced by our perceptions and interpretations of the environment (Padesky, 1994).

According to Beck, the way we interpret environmental events via negative automatic thoughts is a function of our schemas. Schemas develop as part of normal cognitive development, and every individual has self-schemas as well as schemas about others and the world that influence his/her emotional and behavioral reactions (Beck, Emery & Greenberg,

2005; Padesky, 1994). A schema consists of core beliefs and assumptions about oneself, others, and the world. Core beliefs are unconditional in nature and are taken as truths about the self and the world, whereas assumptions are conditional and may be thought of as contingent between events and self-appraisals (Padesky, 1994). Schemas determine what we notice, attend to, and remember of our experiences.

Individuals who suffer from anxiety have maladaptive schemas that contain assumptions and beliefs about danger to one's domain and about one's reduced ability to cope (Beck et al., 2005). These maladaptive schemas are hypothesized to be more rigid, inflexible, and concrete than schemas of normal individuals (Beck, 1967; Beck et al., 2005). Schemas, therefore, seem to be of great influence in the maintenance of emotional problems when they are maladaptive and dysfunctional (Padesky, 1994). Once schemas are formed, they are maintained through the processes of distorting, not noticing, and discounting contradictory information, or by seeing this information as an exception (Beck, Davis, & Freeman, 2015; Bodenhausen, 1988; Hastie, 1981).

Beck's (1967) schema theory of anxiety states that negative automatic thoughts represent the surface cognitive features of schema activation. These negative automatic thoughts are appraisals or interpretations of events that are tied to and influence particular behavioral and affective responses. Beck and colleagues (2005) describe automatic thoughts as rapid, spontaneous thoughts that are an immediate interpretation of a given situation. Automatic thoughts can occur in verbal or imaginal form and are believable at the time of occurrence. Automatic thoughts can arise without the focus or immediate awareness of their occurrence or presence (Beck et al., 2005; Padesky, 1994). Most people are not immediately aware of the presence of automatic thoughts, unless they are trained at monitoring and identifying them (Beck, 1976). Individuals who suffer from anxiety or other emotional disorders tend to have

distorted automatic thoughts and interpret situations through a distorted lens due to these thoughts.

Maintenance

According to Barlow (2002), cognitions (what the person thinks), physiology (bodily reactions) and behaviors (what a person does when he/she is anxious) interact and influence one another. These three components form a cycle that maintains anxiety. When faced with a feared situation, the fearful individual may have thoughts such as “I am in danger” or “I cannot handle this situation”. These thoughts may produce physiological arousal, which provokes additional threatening thoughts such as “I look foolish” or “they will know I am anxious”. These thoughts lead the person to behave in ways to reduce the anxiety, which often involves escape or avoidance.

The person often attempts to cope with the anxiety through behavioral or cognitive avoidance (Barlow, 2002). Behavioral avoidance may be subtle. For example, an individual may look away when speaking with a person of authority or stand behind a table when giving a presentation. Safety behaviors are behaviors an individual feels he/she must engage in order to get safely through an anxiety-provoking situation (Salkovskis, 1991). Safety behaviors can be any behavior an individual performs in order to prevent what s/he perceives to be a “catastrophe” that s/he believes can be prevented with this behavior. For example, an individual may experience panic attacks and sensations that resemble dizziness. This individual may fear that s/he will faint, and every time s/he experiences a panic attack s/he sits down (safety behavior). By doing so, not only does this individual experience immediate relief, but s/he is also maintaining his/her belief that if s/he had not sat down, s/he may have fainted. By sitting down during each panic attack, instead of disconfirming the belief that s/he will not faint by remaining

standing, the individual believes that s/he was almost overtaken by this catastrophe and therefore, saved themselves by sitting down.

Avoidance behavior is an effective short-term solution to reduce an individual's anxiety. When people leave an anxiety-provoking situation, s/he feel a sense of immediate relief. Thus, avoidance is an effective way to reduce anxiety in the short-term and provides negative reinforcement. Because of the immediate initial relief from anxiety, anxious individuals tend to engage in avoidance behaviors in any situation that provokes anxiety in order to feel that relief (Barlow, 2002). This sense of relief "rewards" the individual for avoiding and, therefore, the individual increases his/her engagement in avoidance behaviors. However, In the long-term, avoidance behaviors become detrimental. From a cognitive perspective, avoidance behaviors play an important role in the maintenance of anxiety because they prevent anxious individuals from experiencing an unambiguous disconfirmation of their unrealistic beliefs about feared outcomes (Barlow, 2002). From the perspective of the inhibitory learning model, avoidance behaviors prevent the individual from learning that the conditioned stimulus no longer predicts the unconditioned stimulus (Craske, 2015; Craske, Treanor, Conway, Zbozinek & Vervliet, 2014).

Empirical Support for Treatment

Cognitive Behavioral Therapy (CBT) for anxiety is a time-limited, present focused approach with the goal of identifying and modifying distorted beliefs, reducing avoidance, and supporting more adaptive behaviors. CBT addresses both individuals' belief systems and their patterns of overt and subtle avoidance by integrating exposure, cognitive restructuring, and relaxation training into the treatment. CBT is one of the most researched treatments in psychotherapy and has been shown to be effective in reducing anxiety symptoms and

maintaining the reduction of anxiety symptoms after treatment (Deacon & Abramowitz, 2004; Norton & Price, 2007; Stewart & Chambless, 2009).

For social anxiety, meta-analyses have found that effect sizes for all CBT treatments have been shown to be superior to individuals in the control who received a delay in treatment (Chambless & Hope, 1996; Fedoroff & Taylor, 2001; Feske & Chambless, 1995; Gould, Buckminster, Pollack, Otto, & Yap, 1997; Taylor, 1996). Taylor (1996) found that individuals receiving CBT for social anxiety showed significant increases in effect sizes after follow-up periods of 3 months in duration, which suggests further improvements after treatment ended. A meta-analysis conducted by Fedoroff and Taylor (2001) compared exposure alone, cognitive restructuring alone, social skills training alone, and applied relaxation alone. All interventions showed moderate efficacy after treatment ended and revealed a maintenance of progress rather than further improvement. Other meta-analyses confirmed that the combination of exposure and cognitive restructuring produced an effect size superior to cognitive restructuring without exposure and social skills training (Fedoroff & Taylor, 2001; Gould et al., 1997; Taylor, 1996). One study found that exposure alone and exposure combined with cognitive restructuring produced no meaningful differences post treatment (Feske & Chambless, 1995). These findings highlight the importance of including an exposure component in CBT for social anxiety disorder (Zaider & Heimberg, 2003); however, it has also been suggested that the inclusion of cognitive techniques may reduce the amount of exposure necessary to produce similar outcomes (Turk, Coles & Heimberg., 2002).

With regards to empirical support for interventions for generalized anxiety disorder (GAD), three meta-analytic reviews found that compared to behavior therapy alone (relaxation techniques or anxiety management training) and cognitive therapy alone (cognitive challenging

interventions), a combination of both, cognitive and behavioral elements, was significantly superior at post-treatment and follow-up (Chambless & Gillis, 1993; Covin, Ouimet, Seeds, & Dozois, 2008; Mitte, 2005). Barlow, Raffa, and Cohen (2002) also found that the most effective treatment for GAD combines cognitive therapy with relaxation exercises. In addition, research suggests, CBT results in the largest effect sizes overall when looking at improvement on measures of anxiety and depression at post treatment and at follow-up (Borkovec & Ruscio, 2001). Multiple studies have found that CBT consistently led to clinically significant changes in approximately half of patients (Borkovec & Costello, 1993; Borkovec, Newman, Pincus, & Lytle, 2002; Fisher & Durham, 1999). Furthermore, analyses of within-group effects for follow-up show that gains from treatment are maintained for up to a year (Chambless & Gillis, 1993; Covin et al., 2008; Gould, et al., 1997). Based on the empirical evidence, CBT is an efficacious treatment for both GAD and SAD. Therefore, CBT was the treatment chosen for this case study because the client suffered from both disorders.

Exposure therapy has been identified as an effective treatment strategy for fear and anxiety disorders (Hofmann & Smits, 2008; Norton & Price, 2007). In exposure therapy, the individual is repeatedly and systematically exposed to their feared stimuli. In the absence of repeated aversive outcomes, fear extinction occurs. During exposure, the individual refrains from engaging in avoidance, escape, safety, or ritualizing behaviors to ensure optimal treatment outcomes. Through repeated exposure, the individual's fear elicited by a stimulus gradually decreases, and s/he is said to be habituated (Foa & McNally, 1996).

Recent research suggests that inhibitory learning is central to extinction (Craske et al., 2014; Craske, 2015). The inhibitory model of extinction states that when an individual enters treatment, they have a "threat expectancy" or expect that their feared outcome will occur if they

stay in the anxiety provoking situation. However, when the individual undergoes exposure therapy, the individual develops a “non-threatening expectancy,” in which they learn that the feared outcome is not likely to occur. The non-threatening expectancy then competes with the threatening expectancy (Craske, 2015). That is, after extinction, the anxiety provoking stimulus now has two meanings, the original excitatory meaning (that provokes the anxiety/threatening meaning) and an additional inhibitory meaning (that does not provoke anxiety/non-threatening meaning).

After the completion of exposure treatment, the level of fear that is experienced when the stimulus is re-encountered is dependent upon which expectancy is activated. When the threatening expectancy is activated, the expression of fear is enhanced, whereas, if the exposure-based non-threatening expectancy is activated, the expression of fear is weakened. This theory suggests that the individual must continue to undergo exposures, in different contexts even after extinction, to keep the exposure-based non-threatening expectancy activation stronger than the original threatening expectancy activation (Craske, 2015).

Background Information and Relevant History

Developmental History

David grew up in a small town where everyone knew each other, and his school had about 200 students in total. David reported that his parents went through bankruptcy when he was born and that he and his sister grew up in poverty. David explained that their first “house” was on a farm and consisted of sheets tied to trees to represent walls. After a few years, David reported that his father built them a regular house on the farm. David reported having a good relationship with his parents and sister while growing up. He reported that he was spanked as a child but wished he received more direction from his parents. David currently continues to live

with his parents. His mother is employed, and his father is retired. David has half siblings from his father's past marriages and reported not being close with them.

Medical/Psychiatric History

David presented for treatment due to ongoing significant symptoms of anxiety, which worsened when he started college four years ago. He reported experiencing difficulty concentrating when studying due to his worry. He also reported impairment in his social life due worry and anxiety in social situations. He reported that the anxiety he experiences currently was not impairing for him in the past and therefore he had not sought out mental health services in the past. Growing up, David reported always feeling like he was not good enough, particularly in the context of previous romantic relationships. He reported that he never thought he would be smart enough to finish high school and get into college. He reported that he also believed that he was too poor to go to college until he learned financial aid was available. When he started college, he reported thinking he was not good enough and needed to get perfect grades to prove this belief wrong.

David also reported that his father is currently diagnosed with diabetes and seasonal depression. He reported that his father is an "alcoholic" and is difficult to talk to now. He stated that his father has a temper, and everyone has to "tiptoe" around him. He reported that his mother is battling skin cancer but still working to support the household. David described his mother as reserved in that she does not discuss her feelings.

Social Development

David described himself when he was younger as a shy and observant child with few close friends. He reported that he used to play baseball and football with the neighborhood children, but they were competitive, which he experienced as stressful by creating pressure to

perform well. By about age ten he began isolating himself and spent the majority of his time playing in the woods and biking. David reported watching other children's behavior to know what "not to do." David described instances in his childhood where he would watch other children in public and, if they were scolded by their parents, he would try to analyze what the children did wrong and he would stay away from those behaviors.

After graduating high school, David reported meeting people who encouraged him to be less shy and he began drinking alcohol which helped him be comfortable in social situations. He worked multiple jobs after high school and reported being carefree with frequent partying and drinking. At the age of 21, David developed an intimate relationship with a woman whom he abused drugs and alcohol with. During their relationship, she checked herself into rehab for drug addiction and soon after leaving rehab, he reported she left him to "work on herself and her future". Shortly after, he moved back to his home state to work on himself and his future.

He stopped drinking and started working at a tech company. He reported being close with three friends at this job; however, they were all married with children. David stated that he again began isolating himself and would stay home and play video games. During that time, David reported gaining weight and feeling more self-conscious about meeting people. He reported feeling depressed and began taking measures to lose weight, which he eventually did. Around three years ago, he reported meeting a woman who asked him about his life and what he wanted to do. He panicked and did not have an answer. He reported that she told him at his age he should know what he wants in life. David reported being celibate for 17 years and began feeling anxious about talking about himself to others. He reported avoiding social situations particularly ones that involved women. He also stated that he did not want to be in a relationship because of the high demands and expectations that the other partner will have of him.

Educational History

As a child, David reported going to a public school in the neighborhood he lived in. He reported that his performance was initially average but deteriorated below average as he got older. At around the age of 12, David reported an incident at his school. David explained that he had a love of writing poetry and fictional stories. When the principal of his school got a hold of his writing, she suspected that David experienced suicidal ideation, which David denied. From that point on, David stopped writing and reported feeling anxious about anyone reading his writing. When David was 15, he moved to a big city with his parents and reported feeling anxious and more reserved due to being in a big school. David reported that he did not care about school when he was in high school and believed he would not have an opportunity to go to college. This in turn impacted his grades. He took a job right after graduation. During that time, he learned that there were ways he could be able to get into college, but expressed feeling overwhelmed because of his poor grades. David decided to try and go back to school and moved back in with his parents to save money.

Assessment

DSM-5 Anxiety, Mood, and Obsessive-Compulsive and Related Disorders (DIAMOND)

The Diagnostic Interview for DSM-5 Anxiety, Mood, and Obsessive-Compulsive and Related Disorders (DIAMOND) was utilized to aid in diagnosis (Tolin et al., 2016). The DIAMOND is a new semi-structured clinical interview that queries the DSM-5 diagnostic criteria for the anxiety disorders, bipolar disorders, depressive disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, schizophrenia spectrum and other psychotic disorders, feeding and eating disorders, somatic symptom and related disorders,

substance-related and addictive disorders, and neurodevelopmental disorders. The DIAMOND supplements the diagnostic criteria by providing clinically relevant questions such as symptom dimensions, behavioral observations, and information about common differential diagnoses. The DIAMOND also provides a suicide screen that discusses intent, plan, means, behaviors, and protective factors. The DIAMOND has a corresponding screening form that consists of symptoms questions and is used to facilitate the interview. The self-report screening form consists of a series of yes/no questions that each contain a page number to correspond with each disorder in the DIAMOND interview. The client is asked to fill out the questionnaire before the interview. The interviewer only follows up on questions that were answered with a yes by going to the corresponding page number in the DIAMOND interview.

Reliabilities were obtained by having two interviewers interview the same participant three times; during the initial interview, 48 hours later and one week later. DIAMOND diagnoses show good ($k=.59$) to excellent ($k=1.00$) test-retest reliability which indicates that they would produce similar interview results across two different time points (Tolin et al., 2016). Regarding interrater reliability, kappa values ranged from very good ($k=.62$) to excellent ($K=1.00$). The convergent validity of the DIAMOND diagnoses was verified by showing higher scores on self-report measures for participants with anxiety, mood, and obsessive-compulsive and related diagnoses (Tolin et al., 2016).

Social Interaction Anxiety Scale

The Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998) is a widely used 20-item self-report measure that assesses prevalence, severity, and treatment outcomes for fear of social interactions. Respondents rate their experiences in situations associated with social anxiety on a 5-point Likert scale from 0 (not at all a characteristic of me) to 4 (extremely characteristic of

me). Scoring involves summing the items (including reverse scoring items 5, 9, and 11). Total score scale range from 0-80, with higher scores indicating higher levels of anxiety in social situations. The cutoff score of 34 is used to identify individuals who are likely to meet criteria for social anxiety disorder. From a clinical population of individuals with SAD the SIAS produced a mean score of 49 and a standard deviation of 16. The SAIS has been shown to be reliable with a Cronbach's alpha range of .88 - .94 and a test-retest correlation of .92 after 4 weeks and 12 weeks (Mattick & Clarke, 1998). Refer to appendix C to view the SIAS self-report measure.

Penn State Worry Questionnaire

The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) is a 16-item self-report questionnaire assessing the generality, excessiveness, and uncontrollability of worry. The scale has been shown to identify clinically significant worry, over and above anxiety and depression. Items are rated on a five-point scale from 1-Not at all typical of me to 5-Very typical of me. The possible range of scores is 16-80, with higher scores indicative of higher levels of trait worry. Scoring involves summing the item responses after reverse scoring items 1, 3, 8, 10, 11. The total mean score for an adult community sample on the PSWQ was reported as 41 ($SD = 11$) by Gillis, Haaga, and Ford (1995). The mean for people diagnosed with GAD has been reported as 68 ($SD = 10$) (Mennin, Heimberg, Turk, & Fresco, 2001). Individuals with GAD will typically score higher on the PSWQ compared with other anxiety disorders. The PSWQ has demonstrated strong internal consistency (Cronbach's $\alpha = .86-.95$) and a test-retest reliability of .92 - .93 after 4 weeks in students and clinical samples (Brown, Antony, & Barlow, 1992; Meyer et al., 1990). The PSWQ was found to positively correlate with other emotional disturbance assessments related to pervasive worry such as perfectionism, and time urgency with respective r values of .39 and .47. The PSWQ also

positively correlated with specific maladaptive ways of coping with environmental stress such as self-blame, wishful thinking and dread, and ignoring the situation with respective r values of .52, .45, and .41. Higher scores on the PSWQ indicate higher levels of self-blame, wishful thinking, and problem avoidance. The PSWQ correlates less so with other measures that are not related to worry, indicating that it looks into an independent construct in individuals. For example, when the PSWQ was compared to the Beck Depression Inventory an r value of .36 was produced (Meyer et al., 1990). Refer to appendix B to view the PSWQ self-report questionnaire.

Beck Depression Inventory

The Beck Depression Inventory (BDI) is a 21-item, self-report rating inventory that measures symptoms of depression in affective, cognitive, behavioral, somatic and motivational domains in adults and adolescents over the age of 13 (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). Scoring consists of summing all of the responses. Each item is rated on a scale of 0-3, producing a range of scores from 21 to 63. Research suggests scores of 0–9 indicate that a person is not depressed; scores of 10–18 indicate mild-moderate depression; scores of 19–29 indicate moderate-severe depression; and scores of 30-63 indicate severe depression (Beck, Steer, & Garbin, 1988). The BDI has demonstrated high internal consistency with alphas reported from .76 to .95 for psychiatric populations with a mean coefficient alpha of .86. Internal consistency for the nonpsychiatric populations ranges from .73-.92 with a mean alpha of .81 (Beck, Steer, & Garbin, 1988). Test-retest reliability ranges from .48-.86 in psychiatric patients and .60-.83 for nonpsychiatric participants (Beck et al., 1988). Convergent validity for the BDI has been investigated ,producing favorable correlations with clinical ratings, the Hamilton Psychiatric Rating Scale for Depression (HRSD, Hamilton,1960), Zung self- reported Depression Scale (Zung, 1965), the MMPI depression scale (MMPI-D), and the Multiple Affect

Adjective Checklist Depression Scale (MAACL-D; Zuckerman & Lubin, 1965). In studies with psychiatric patients using these measures, correlations have ranged from .55-.96 with a mean correlation coefficient of .72. The mean correlation coefficient for nonpsychiatric samples has been reported as .60. Therefore, there is strong support for the BDI's ability to differentiate between psychiatric and nonpsychiatric samples (Beck et al., 1988). The BDI was utilized in the initial stages of assessment to provide a baseline for symptomatology. David's initial score of an 8 indicated that David is within the normal range and is not experiencing symptoms of significant depression. Refer to appendix D to view the BDI self-report inventory.

Anxiety Sensitivity Index

The Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gursky, & McNally, 1986) is a 16 item self-report measure that assesses sensitivity to and fear of anxiety related sensations and possible negative consequences to the experience of anxiety. Items are rated on a 5-point Likert scale (0- very little, 1-a little, 2- moderate, 3- much, 4-very much). It is scored by summing ratings across the 16 items. Possible total scores range from 0 to 64, with higher scores reflecting higher levels of anxiety sensitivity. Internal consistency appears to be good to excellent, ranging from $\alpha=.82$ to .91 (Peterson & Reiss, 1993). The test-retest reliability is adequate with correlations ranging from .71 to .75. The mean inter-item correlations for the ASI were statistically significant (.35 for sample 1, N=49 and .42 for sample 2, N=98) (Reiss et al., 1986). A factor analysis revealed a single factor structure in which 13 of the 16 items had a loading of .4 or more on the first factor. Similar results were obtained from a factor analysis on sample 2. The correlation between anxiety sensitivity and fearfulness was much larger than that between anxiety frequency and fearfulness with respective r values of .59/.71 and .37/.44 for both samples. This finding shows that the ASI provides a distinction between anxiety sensitivity and

anxiety (Reiss et al., 1986). The ASI was utilized in the initial stages of assessment to provide a baseline for symptomatology. David's initial score of 12 indicates that he is within the normal range and experiences minimal fear of anxiety symptoms. Refer to appendix E to view the ASI self-report measure.

Sheehan Disability Scale

The Sheehan Disability Scale (SDS; Sheehan, 1983) includes a three item self-rated questionnaire designed to measure how work, social life, and family life are impaired by current psychological symptoms such as anxiety and depression. In the first three items, respondents are asked to indicate how much their symptoms have disrupted their regular activities over the past week in each of these areas using numerical ratings of 0-10 for each item. The ratings from the three individual item scores can then be summed into a single measure of global functional impairment that ranges from 0 (unimpaired) to 30 (highly impaired). Although there are no formal norms or recommended cutoff scores, the author suggests a score > 5 on any of the three scales may indicate significant functional impairment. The final items ask patients about the number of days on which their symptoms caused them to miss school and/or work, the interference of their symptoms with normal work and social activities and how much the symptoms caused them to be underproductive at school and/or work (this item is not included in the SDS total score). The Sheehan Disability Scale showed internal reliability with a coefficient alpha ranging from .56-.86 for patients with panic disorder (Leon, Shear, Portera, & Klerman, 1992). Internal reliability in a sample of primary care outpatients assessed for mental health disorders was shown to be excellent ($\alpha = .89$) (Leon, Olsson, Portera, Farber, & Sheehan, 1997). Refer to appendix F to view the SDS self-rated questionnaire.

Acceptance and Action Questionnaire

The Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) is a self-report measure designed to assess experiential avoidance, including the need for emotional and cognitive control, avoidance of negative private events, inability to take needed action in the face of private events, and forms of cognitive entanglement. Example items include “When I feel depressed or anxious, I am unable to take care of my responsibilities;” and “I am able to take action on a problem even if I am uncertain what the right thing to do is” (reverse scored). The construct of experiential avoidance has been conceptualized as “psychological inflexibility” (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Items are scored on a 7-point Likert scale ranging from 1 (never true) to 7 (always true), with higher scores indicating a higher level of experiential avoidance. To calculate a total score, all of the ratings are added after items 1, 4, and 7 are reverse scored. Internal consistency for the AAQ has been reported to range from Cronbach’s alpha = .70–.79 (Bond & Bunce, 2003; Hayes et al., 2004). Convergent validity of the AAQ has been supported by studies reporting significant correlations between the AAQ and numerous measures of psychopathology and quality of life measures (Hayes et al., 2006). Test-retest reliability of the AAQ over a 4-month period was found to be $r = .64$ (Hayes, et al., 2004). Total scores range from 9 to 63 with higher scores indicating more experiential avoidance. In clinical and normal populations, scores of 42 and 38 represent the upper quartile of experiential avoidance, respectively. David’s initial total score of 35 indicates that he experiences some experiential avoidance. Specifically, David reported almost always worrying about getting his anxiety, worry and feelings under control, fearing his feelings by being concerned that his feelings will hold him back, and stating that “anxiety is bad”. Refer to appendix G to view the AAQ self-report measure.

In addition to formal assessments, informal assessments were administered throughout treatment. Self-report ratings of worry, the worry record, and the progressive muscle relaxation practice log (Craske & Barlow, 2006) were utilized throughout treatment to monitor David's progress in treatment.

DSM Diagnoses

300.02 Generalized Anxiety Disorder

300.23 Social Anxiety Disorder

301.4 Obsessive-Compulsive Personality Disorder (Provisional)

David was diagnosed with a primary diagnosis of Generalized Anxiety Disorder (GAD) comorbid with Social Anxiety Disorder (SAD). As treatment progressed, a secondary provisional diagnosis of Obsessive-Compulsive Personality Disorder (OCPD) was given. *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed; DSM-5; APA, 2013) describes GAD as "Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)" (p.222). When preparing for class readings, projects, tests or homework, David reported worrying about receiving a failing grade that would lead to a lowered GPA. David also reported worrying about his and his family's health, their financial future, and his future career. David also described difficulty stopping the worry and believes that, if he stops worrying, something horrible will happen such as not being able to help someone in need or finish his work. David reported symptoms of being easily fatigued, experiencing difficulty concentrating/mind going blank, muscle tension and difficulty staying asleep which are symptoms consistent with GAD (APA, 2013, p.222). He reported experiencing the anxiety since he started university 4 years ago and that the worry, anxiety, and physical symptoms are causing

him distress in his social and work life and are getting “out of control” now. David also reported engaging in safety or avoidance behaviors such as being extra early to appointments and class and not giving himself breaks when studying. David reported that the anxiety and worry cause him clinically significant distress and impairment in school and his social and leisure life

In addition to GAD, David also reported symptoms that were consistent with SAD and warranted a comorbid diagnosis. *The DSM-5*(APA, 2013) describes SAD as a “marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.” David reported avoiding some social situations completely and, if he remained in those social situations, he would experience intense anxiety. He worried that the other individual would think he is not smart and good enough and that others may make fun of him. He feared not saying the right thing, making a fool out of himself, and making mistakes while talking or presenting and being negatively evaluated. David reported that the anxiety was heightened when speaking with someone of authority such as a professor, a high achieving student, or students in “esteemed” degrees such as engineering. He avoided asking professors questions as much as possible. He avoided talking about himself with others, especially someone he is attracted to, because he is afraid that he is not good enough. For the first few sessions, David refused to share his log of his automatic thoughts and the challenging thoughts worksheets because he worried that the therapist would misinterpret his writing and think his thoughts were “stupid”. David also reported that he does not eat in public due to the fear of being watched and judged while eating. When asked how long he has been experiencing these symptoms, David provided examples from years prior and childhood and reported that now he does not have a social life. He reported that he would like to connect with someone one day but is worried about letting the other person down; hence, he completely avoids relationships. David reported

significant interference and distress in his social and academic life due to these symptoms. David denied any medical conditions or substance use, which further supports the diagnoses of SAD and GAD.

After multiple sessions with David, therapist took notice of patterns of behaviors contributing to slow progress in treatment and consistent with obsessive-compulsive personality disorder (OCPD). *The DSM-5*(APA, 2013) describes OCPD as a “pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts.” David engaged in emotional avoidance, which is referred to an unwillingness to experience or remain in contact with unpleasant emotions, thoughts, and sensations, coupled with deliberate attempts to escape from and avoid these experiences due to experiencing discomfort with his emotions. David also experiences some experiential avoidance which indicates that he attempts to control or suppress his negative inner experiences (rather than enduring or tolerating them), paradoxically leading to increased suffering. Throughout sessions, it was difficult to complete the agenda for session. David would be preoccupied with details and rules to the extent that the major point of the activity was lost (criterion one). For example, when working on cognitive restructuring during session, David would fixate on the “disputing questions” worksheet to assist with challenging his thoughts, and would question where the questions came from, what population they were used on (e.g., male/female? Adults/children?), what study was used to show that these questions would help, and how often did they help? This session ended without utilizing the disputing questions worksheet.

The second OCPD criterion that David met is the perfectionism that interferes with task completion. For example, David found great difficulty labeling his thoughts because he wanted

to find the “best” answer and as a result would come to session with an incomplete assignment. Criterion three for OCPD was also met as David was also excessively devoted to his work and productivity to the exclusion of leisure activities and friendships. He reported that he does not have time for a social or leisure life and that part of his life is the most impaired for David. For example, David reported that the next “break” he would get from work or studying is in the summer, which was seven months away.

Throughout sessions David exhibited rigidity with regard to assigned work as well as practice in session which fulfills OCPD criterion eight. For example, when discussing diaphragmatic breathing, David reported that he tried to do it for an exact amount of time which did not help. Therapist then explained that it is tailored to each individual. Another example is when therapist discussed examples of hypothetical situations with David in session and asked him about his thoughts and what he thinks he would do. David would say things such as “I am not there so I don’t know” or “I would usually plan out my time there or my day and this would not happen without me knowing about it before.” David reported that he is not interested in working in a group as he believes not everyone will work to his same standards, and he does not like the pressure of “being liked,” as they may have more expectations of him. As discussed previously, David also reported avoiding intimacy, and, although it is not a specific criterion, in individuals with OCPD this can be characterized as an apparent formality and social detachment which stems from discomfort with emotions and excessive devotion to work (APA, 2013). As a result, David expressed a pattern of controlling his affection would attempt to avoid “deep” or intimate conversation with others.

Research suggests that experiential avoidance appears to be most strongly related to maladaptive perfectionism, which is the core feature of OCPD (de Reus & Emmelkamp, 2012).

Even after controlling for maladaptive perfectionism, these authors found experiential avoidance was related to attempts at emotional control, rigidity (criterion eight of OCPD) and difficulty with change, but did not relate to reluctance to delegate, suggesting emotional avoidance is more relevant for some OCPD features than others (Wheaton & Pinto, 2017). The OCPD diagnosis was given as a provisional diagnosis because it was mainly through observation and no further psychological evaluations were administered for this.

Differential Diagnosis

During the intake, David discussed preoccupation with his physical appearance, particularly his stomach. He reported experiencing embarrassment by how his stomach looked and attempted to walk towards others and not perpendicular to them. He reported that if someone was walking towards him from the side, he would turn to face them so they were not able to see his stomach. David reported repeatedly sucking his stomach in when sitting in public and when he is around other people. For example, he reported that when studying in the library, he attempts to find a seat where not many people would walk by. If people did walk by, he would make sure to suck his stomach in until they passed him.

At first, the diagnosis of body dysmorphic disorder was considered. After following up with additional questions, David reported that his concern with his body was due to his concern about how other people viewed him. He stated that in the past he was overweight, and he lost the weight. When he started school, it was difficult to maintain the same routine, and he started gaining a little bit of weight, particularly around his stomach area. He reported insecurity about that area, especially in the presence of strangers. When he is with his family or close friends (who he is currently not in contact with due to believing he is unable to connect with them), he reported being comfortable and reported not thinking about his body image. However, when he

is around people he does not know or is not close with, he experiences anxiety and has the belief that individuals might find him unattractive and unapproachable and believes that they will ridicule or reject him because of his physical features. He reported thinking people won't talk to him because he is "overweight." This information ruled out body dysmorphic disorder because the concerns appear to be consistent with his diagnosis of social anxiety disorder.

Although generalized anxiety/ worry and social anxiety are a common associated feature of a depressive disorder, David did not report experiencing depressed mood or loss of interest or pleasure. David reported experiencing difficulty staying asleep, concentrating and experiencing fatigue, symptoms similar to those in major depressive disorder; however, due to insufficient symptoms to meet criteria and due to the pattern of these symptoms, they were better explained by David's generalized anxiety. Individuals with major depressive disorder may be concerned about being negatively evaluated by others because they feel they are bad or not worthy of being liked. In David's case, he was worried about being negatively evaluated because of certain social behaviors or physical symptoms in these situations. Therefore, a diagnosis of major depressive disorder was ruled out.

Case Conceptualization

David presented with multiple contributing factors to the development of his anxiety, which include the interaction of his generalized biological vulnerability, generalized and specific psychological vulnerabilities, and stressors. As discussed previously, since David's father suffers from depression, it could be the biological/genetic predisposition that David acquired from his father. A generalized psychological vulnerability is thought to develop when a child lacks a sense of control over negative events and/or getting his needs met. David experienced poverty early in life in which it was difficult for the family to get its needs met. As discussed above,

David's family faced financial difficulties that lead to losing their home and impacted their ability to access food and lost their home. When David and his family moved to the city, the move was a negative event to David that he had no control over. David explained that it was difficult to adjust to moving to a new school and a city with more people, as he was used to spending his time alone in the woods.

David also experienced difficulty getting his emotional needs met in childhood. David reported that his father isolates himself from the family, and his mother does not express her feelings. He stated that, in their home, there was an expectation to "not make the other person upset." David explained that, to this day, his mother struggles to make ends meet (as she is currently the only employed parent) but refuses to express that to her husband. Even as an adult, As discussed, David reported that he finds it difficult to express his feelings with his family, particularly his father. For example, he does not ask his father if he needs help or offer advice, as David worries he might make his father angry. He also does not express his interest in moving out after graduation, as he fears they will be disappointed in him. He learned to inhibit his feelings and act in such a way to "not upset or bother others."

He explained that he did not have much direction growing up and his parents had a permissive parenting style. Through vicarious learning, David would watch other children's behavior in order to behave the "correct" way. This led to David being hyper aware of his surroundings and being strict and rigid with regards to his behavior, which gives him a sense of control.

David reported stressors that occurred and influenced the development of his anxiety. As discussed above, David reported associating his previous relationships with his perception of being a disappointment to others. Another example is that David spoke to a woman a few years

prior to treatment who asked him what he wanted to do with his life and asked him personal questions about himself. He reported perceiving himself as lost and not knowing how to answer her. This led to him thinking he does not know himself, and he avoids talking about himself all together in fear of being asked questions he cannot answer.

Another aspect that strengthens the development of David's anxiety is his beliefs about himself ("I am not interesting," "I am not smart"), and his use of rigid rules or standards for how he should act as well as having unrealistically high standards ("I must show that I know what I am talking about and be seen as smart, so there can be no pauses when I speak," and "I should not feel anxious"). Another belief that David manifests that may not be recognized from the surface is low confidence in his problem-solving abilities, perhaps due to worries over making the "wrong" decision. David's beliefs about himself underlie the automatic thoughts he experiences constantly that serve to trigger his anxiety. These thoughts influence how he feels (anxious) and his physiological sensations (e.g., irritable, tense) which also influence his behavior (avoidance).

A component that drives the maintenance of David's anxiety is his avoidance of internal as well as external stimuli that promote an anxious state. For example, David avoids monitoring his thoughts, as he believes that paying attention to his thoughts is what makes him experience more anxiety. He also avoids situations that make him feel anxious such as social situations, presentations, and breaks from studying. David also engages in excessively preparing for assignments and projects as well as making sure to be extra early for any appointment; these safety behaviors help him to avoid his feared outcomes of failing and being judged negatively by others.

Treatment Goals and Plan

Individual CBT targeting both GAD and SAD was recommended to manage the anxiety contributing to David's impairment at school and social life and to improve his ability to cope with worry (Craske & Barlow, 2006; Hope, Heimberg, & Turk, 2010). Specifically, long term goals for treatment included:

- 1) Reduce overall frequency, intensity, and duration of the anxiety so that daily functioning is not impaired;
- 2) Become an objective observer of his own anxiety and worry;
- 3) Learn and implement coping skills that result in a reduction of anxiety and worry and improve daily functioning;
- 4) Enhance ability to effectively cope with the full variety of life's worries and anxieties;
- 5) Apply skills learned during exposures to images in anxiety provoking situations, without engaging in overt or subtle avoidance behaviors.

The general plan of treatment for David was tailored to target both his GAD and SAD symptoms utilizing cognitive behavioral therapy as described by Craske and Barlow (2006) and Hope, Heimberg, and Turk, (2010) The plan utilized multiple components including assessments, psychoeducation, self-monitoring, relaxation training, cognitive restructuring, imagery exposure, problem solving training, in-vivo exposure, interpersonal interventions, and relapse prevention. The plan for each of these areas is discussed below.

Assessment

Assessments utilized in treatment included an in-depth, structured clinical interview to establish diagnostic features and relevant questionnaires for presenting problems. As discussed, in this specific case, a standard Intake interview and the DIAMOND were utilized. Initial contact questionnaires in pretreatment and throughout treatment were utilized and were previously

discussed in detail. Another consideration during the intake assessment was for medication as well as assessing the nature and degree of worry and anxiety symptoms.

Psychoeducation

Next, psychoeducation about GAD, SAD and cognitive-behavioral therapy was provided. Part of psychoeducation includes informing and correcting misconceptions regarding anxiety, worry, and associated symptoms. Another aspect of psychoeducation describes situations, thoughts, feelings, and actions associated with anxieties and worries, their impact on functioning, and attempts to resolve them. This also includes discussing how GAD typically involves excessive worry about unrealistic threats, various bodily expressions of tension, over arousal, and hypervigilance, and avoidance of what is threatening that interact to maintain the problem. Therapist then would teach the client about the maintenance model of SAD and discuss how social apprehension is associated with unrealistic social standards and avoidance. After psychoeducation, therapist would provide the treatment plan and rationale for treatment as well as develop short-term and long-term goals.

Self-Monitoring

After psychoeducation, the therapist would teach the client to observe his reactions from an objective standpoint and to chart progress in therapy. The client is then asked to complete a daily mood record at the end of each day to record overall or average levels of anxiety, depression, and worry about panic. Throughout treatment, the client would keep track of significant episodes of worry (Worry record) to provide description of cues, maximal distress, and symptoms, thoughts, and behaviors. Through this process, the client would learn and implement a strategy to limit the association between various environmental settings and worry, delaying the worry until a designated “worry time”.

Relaxation Training

During treatment, therapist would teach the client how to implement calming skills to reduce overall anxiety and manage anxiety symptoms. These skills include diaphragmatic breathing, or deep breathing, and progressive muscle relaxation, which is a systematic conscious tensing and relaxing different muscle groups in the body to induce relaxation.

Cognitive Restructuring

Therapist would then verbalize an understanding of the role that cognitive biases play in excessive irrational worry and persistent anxiety symptoms. Therapist would teach the client to observe the association between anxious mood and automatic thoughts. During session, the client is asked to evaluate the costs and benefits of worries in which he lists the advantages and disadvantages of the negative thought, fear, or anxiety. The client is then instructed about how to identify maladaptive beliefs and automatic thoughts by exploring client's schema and self-talk that mediate his response. Therapist then would assist client in challenging the biases of maladaptive ways of thinking and work with the client to replace the distorted messages by formulating reality-based, rational alternatives to these beliefs and thoughts.

Imagery exposure/practice in session

After learning the previous skills discussed, the next step would be to undergo gradual repeated imaginal exposure to the feared negative consequences predicted by worries and develop alternative reality-based predictions. The first step to start this process is to direct and assist the client in constructing a hierarchy of two to three spheres of worry for use in exposure. Therapist and client collaboratively select initial exposures that have a high likelihood of being a success experience for the client; develop a plan for managing the negative effect engendered by exposure; mentally rehearse the procedure. Therapist would then guide the client to imagine a

worst-case scenario, after which he generates alternative outcomes to the scenario. The client would then utilize cognitive restructuring and relaxation skills during imagery exposure to anxiety-provoking situations (self-controlled desensitization). Therapist would utilize behavioral techniques such as instruction, rehearsal, role-playing, role reversal as needed to assist adoption into the client's daily life; reinforce success.

Problem-solving training

As with any treatment, problem solving training is implemented in treatment for client to apply them to situations that cause stress/anxiety. Therapist would teach the client problem-solving strategies involving specifically defining a problem, generating options for addressing it, evaluating the pros and cons of each option, selecting and implementing an optional action, and reevaluating and refining the action.

In-vivo exposure

Exposure then expands to real anxiety provoking situations. The client would engage in repeated exposure to situations that are avoided or engaged in with excessive preparation or checking (e.g., talking about self with others, arriving on time instead of excessively early at scheduled appointments, saying 'no' to requests). Specifically, the exposure includes inhibitory learning enhancement and inhibitory regulation enhancement strategies. These strategies include a combination of 6 components. The first is expectancy violation which designs exposures that maximally violate expectancies regarding the frequency or intensity of aversive outcomes. The more the expectancy can be violated by experience, the greater the inhibitory learning. In this approach, exposure tasks are designed to accommodate "what do you need to learn" rather than by fear reduction or "stay in the situation until fear declines". The second component is deepened extinction which combines multiple cues in exposure after initially conducting some exposure to

each cue in isolation. Third is occasional reinforced extinction which encourages clients to seek the opportunity for occasional negative outcomes. This represents another way in which an inhibitory learning occurs. Fourth is the removal of safety signals or safety behaviors as discussed previously. The fifth is variability (exposure on random items on hierarchy) which is more likely to characterize contexts in which stimuli is encountered in the real world. This includes conducting exposure to items from the hierarchy in random order, without regard to fear levels or fear reduction. And conducting exposure with varying stimuli, varying durations, at varying levels of intensity, or select items from a fear hierarchy out of order. The sixth and last components is conducting exposures in multiple contexts (alone, in group, day, night).

Interpersonal interventions

Depending on the client, interpersonal interventions may be utilized. This would include the use instruction, modeling, and role-playing to build the client's general social, communication, and/ or conflict resolution skills.

Relapse prevention

As with any treatment, relapse prevention is utilized. Here the therapist would discuss with the client the distinction between a lapse and relapse. The therapist would also identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. The therapist would also instruct the client to routinely use new therapeutic skills (e.g., relaxation, cognitive restructuring, exposure, and problem-solving) in daily life to address emergent worries, anxiety, and avoidant tendencies. Therapist would also collaborate with the client to come up with retrieval cues that the client will carry with him to remind him of what he learned during exposure therapy.

Course of Treatment Tied to Treatment Plan

Consistent with cognitive behavioral therapy for GAD and SAD in adults, treatment included a diagnostic interview and objective assessments, psychoeducation about treatment, worry, anxiety, self-monitoring, relaxation training, and cognitive restructuring of maladaptive thoughts. Client left treatment prematurely and did not complete imagery exposure/in vivo exposure, problem solving training, and interpersonal interventions in the treatment plan.

Diagnostic Assessments

The first three sessions consisted of assessments and a diagnostic semi-structured interview discussing the presenting problem, a history of symptoms, and overall functioning and impairment. The therapist asked David questions on the DIAMOND that correspond to his answers on the DIAMOND screen. David was also given the PSWQ, SIAS, BDI, ASI, SDS, and the AAQ as baseline measures. After diagnoses, only the PSWQ, SIAS, and SDS were given throughout treatment to monitor progress. The diagnostic interview spanned out to three sessions because David reported being worried that he was not providing the “correct” answers or the “right way” of answering to the therapist. When asked questions, David would become fixated on the format of the question, and therapist would continuously cue him back to answering the particular question. For example, when asked “In the past month, if you can’t avoid (situation), do you feel intensely anxious?” David would reply “what do you mean by intensely?” When therapist would rephrase the question, David would reply by stating “I don’t know if the intensity of the anxiety that I feel is at the same level of your definition of intensity.” During the first few

sessions, David reported thinking treatment would not work but that he was “willing to try it out and maybe learn something along the way.”

David’s initial total score on the SIAS was 41, which indicated that David had been experiencing clinically significant anxiety in social interactions. David strongly endorsed items such as becoming tense if he has to talk about himself or his feelings, worrying that he won't know what to say in social situations, experiencing difficulty talking with someone he is attracted to, as well as worrying about expressing himself in case he appears awkward. During the first month of treatment, David reported reduced fear of social situations. During this time, David reported avoiding social situations and feeling an immediate relief, hence the drastic decrease in his score to be in the normal range with a score of 25. During the second month, David reported more anxiety in social situations due giving presentations and working on group projects for his class, hence the increase of his score to a 42. Refer to Table 1 for a summary of scores throughout treatment.

Table 1: Monthly SIAS scores

SIAS throughout treatment		
	Score	Interpretation
Pretreatment	41	Similar to individuals with SAD
1 Month	25	Within the normal range
2 Month	42	Similar to individuals with SAD
3 Month	36	Similar to individuals with SAD

David's initial score of 68 on the PSWQ indicated that his score is similar to individuals who are diagnosed with GAD. David endorsed items such as worrying about everything else he has to do as soon as he finishes a task, worrying about projects until they are done, worrying about his concerns even when there is nothing more, he can do about it, and finding it difficult to dismiss worrisome thoughts. As treatment progressed, David's score decreased as he reported being more comfortable monitoring his thoughts and challenging them. Refer to table 2 for a summary of his scores throughout treatment.

Table 2: Monthly PSWQ scores

PSWQ throughout treatment		
	Score	Interpretation
Pretreatment	68	Similar to individuals with GAD
1 Month	66	Similar to individuals with GAD
2 Month	58	Similar to individuals with GAD but one SD lower than at pretreatment
3 Month	58	Similar to individuals with GAD but one SD lower than at pretreatment

David's initial scores on the SDS indicated that his anxiety is not impairing his work (scored 0/10), his score on his social/leisure activities indicates that he experiences severe impairment (scored 10/10), and his score on family life/home responsibilities indicate he experiences no impairment at home (scored 0/10). David's total score on the SDS is a 10, but looking closely at each score David's social/leisure life appears to be markedly impaired.

David's social life remained impaired throughout treatment with a slight improvement. Refer to table 3 for a summary of scores throughout treatment.

Table 3: Monthly SDS scores

SDS throughout treatment		
	Score	Interpretation
Pretreatment	10	Very Severely Impairing (Social life & Leisure activities)
1 Month	9	Very Severely Impairing (Social life & Leisure activities)
2 Month	8	Markedly Impairing (Social life & Leisure activities)
3 Month	9	Very Severely Impairing (Social life & Leisure activities)

Psychoeducation

During treatment, David was given psychoeducation about the three components of anxiety (i.e., thoughts, physiological responses, and behavior), the etiology of anxiety (i.e., general biological vulnerability, general psychological vulnerability, specific psychological vulnerability), and how the anxiety is maintained and perpetuated (i.e., avoidance, reassurance seeking, safety behaviors).

Specific Examples

David collaborated with therapist by giving examples of situations that trigger his anxiety. For example, he reported feeling anxiety about being late for school or for his sessions with the therapist. He reported that he does not like to wait on other people and does not want to do the same to them. He also reported worrying about letting other people down and “wasting

their time” if he is late. He reported automatic thoughts during this situation of “It is bad to be late” and “If I am late people will think I am not serious” and “I am wasting other people’s time if I am late.” He reported feeling anxious (emotion) and waking up at 4 am so he is able to start his morning and drive 30 minutes to make it to his 10 am session (behavior). He reports that he leaves extra early because he is afraid there will be trucks in front of him or cars that will drive slowly, which will result in him being late. He also reported that in case his car breaks down or an accident happens on the road he would have enough time to deal with it and not be late to where he needs to go. Using David’s examples, therapist also provided psychoeducation about the influence of David’s thoughts on his feelings and behaviors, the physiological symptoms he experiences, the nature and cycle of worry in David’s life and introduced how treatment targets worry, anxiety symptoms, and avoidance to help the client manage worry effectively, reduced over arousal, and eliminate unnecessary avoidance as explained by Craske and Barlow (2006) and Hope, Heimberg, and Turk, (2010).

Monitoring

David engaged in routine monitoring of the three components of anxiety in his daily life. He would report his thoughts, the physiological sensations he experienced, and labeled the feelings he experienced that situation. An example of a situation was when David was watching a TV show and reported sensations of tension and tightness on his shoulders along with a racing heart rate. He reported thinking “What did I forget to do?” and “I have so much to do and I am wasting time watching TV.” He then stated feeling anxious and angry at himself. David also regularly monitored his mood using the daily mood record. Throughout treatment David’s daily average anxiety would fluctuate. David only completed three weeks of monitoring due to him deciding “it was a waste of time” to sit and rate his anxiety. He also reported difficulty rating his

anxiety with a number using the 0-10-point scale. On some days, he would rate his anxiety at .5 or 2.5 out of 10. After two weeks of monitoring, David refused to continue monitoring his average anxiety, worry and panic as he decided it took time away from the things he needed to do as well as fearing he may have the “wrong” number that may not be exactly representative of what he is experiencing. He reported spending a massive amount of time thinking about where his anxiety lies on the scale. David also reported this problem when filling out the questionnaires (PSWQ, SIAS, & SDS).

Cognitive Restructuring

Another focus of treatment included cognitive restructuring. Along with daily monitoring, therapist discussed dysfunctional thinking patterns and how they color our view of new situations, so we are more likely to view the situation as threatening instead of neutral or an opportunity. Therapist provided psychoeducation about cognitive restructuring and explained that in order to manage anxiety it is important to change our perspective about a situation by targeting our thoughts, beliefs and interpretations as they influence feelings and behaviors. When David was asked to discuss a situation that made him anxious and what thoughts and feelings he felt in that situation, David reported recording a meeting with his advisor and listening to it later to make sure he did not miss any points. While listening to the recording, David reported having thoughts such as “She will think I don’t know what I am talking about because I am pausing so much” and “I should not have asked her so many questions.” He reported feeling embarrassed and tense. When asked how he would feel if he had thoughts such as “everyone pauses when they are thinking while talking” and “an advisor is there to help the students and answer all questions” and other alternative thoughts, David stated that it was difficult to say how he would feel because he is not in that situation right now.

Thinking Errors

David had some success learning to identify and label his automatic thoughts by using the list of thinking errors worksheet (Hope, Heimberg, & Turk, 2010). Examples of thinking errors that David engaged in were “disqualifying the positive” “mental filter”, “mind reading”, “should statements,” and “catastrophizing.” David would consistently do well in school and be at the top of his class when it comes to assignments, tests, and projects. However, he would say “I missed 2 points, what did I do wrong?” (disqualifying the positive, mental filter) when looking at his grades. He reported experiencing anxiety when watching his grade in the class fluctuate by the decimal (97.5% to 97.3%) thinking “I am not doing enough” and “I’ll get a B or fail and not have a 4.0 GPA” (catastrophizing). Another example of a thinking error discussed was when David thought “she thinks I am not prepared and don’t know what I am saying because I paused too much” (mind reading) after speaking with his advisor. One other example of thoughts David experiences is “I should not be anxious” (should statement) when he is in a specific situation. In the beginning David had difficulty labeling his thoughts because he wanted to choose the “right” thinking error. Therapist discussed with David that there can be multiple thinking errors for one thought.

Disputing Questions

Although David did not consistently complete logs of identifying and labeling his thoughts, he appeared to label his thoughts throughout treatment in session when discussing his week. Therapist then discussed ways to challenge automatic thoughts by questioning them. Therapist provided David with the disputing questions worksheet from the Managing Social Anxiety Manual (Hope, Heimberg, & Turk, 2010) to provide him with an example of questions he could use to challenge and dispute his thoughts. Examples of questions offered were “What

evidence do I have that ___?”, ” Do I know for certain that ____? ““What would I say to help a friend who was having this thought?”, “What is the worst that could happen? How bad is that? Is ___ really so important or consequential? “How can I cope with that?”. Next, David would answer the disputing questions like an internal dialogue between his anxious self and his coping self and write them down. David would then summarize the answers into one phrase coming up with a rational response. David was encouraged to use this rational response every time he has the corresponding anxious automatic thought. David reported utilizing the rational response and finding it helpful.

Relaxation Training

Another aspect of treatment consisted of teaching David to implement calming skills to reduce overall anxiety and manage anxiety symptoms in anxiety provoking situations and during cognitive avoidance (Craske & Barlow, 2006). Therapist provided psychoeducation about the influence of breathing and tension on anxiety and how we can counteract that influence through diaphragmatic breathing and progressive muscle relaxation techniques. When this part of treatment was discussed, David reported that he has tried breathing techniques, in the past, and they have not worked for him. He reported that the pace of the breathing he has used before through a guided recording was too fast for him. Therapist assured David that the technique would be tailored to what is most comfortable for him. Therapist provided handouts describing the steps of diaphragmatic breathing and progressive muscle relaxation and facts about how they influence the relaxation response of the body. Therapist practiced these techniques in session with David and instructed David to practice these techniques throughout the course of treatment. Therapist described the importance of practicing these skills daily to be able to learn how to discriminate between relaxation and tension and induce relaxation when experiencing anxiety.

David reported inconsistency with practicing the techniques in his daily life. He reported that it was difficult for him to tense and relax all the muscle groups and stated that there were some areas (his upper body) that stayed tense even after “relaxing.” Therapist discussed ways to target these muscle groups, and David agreed to try using weights when tensing his upper body and letting go of the weights when relaxing to have a bigger impact when he relaxes.

Avoidance

Therapist also discussed safety behaviors and coached David to cease engaging in them and confront his avoidance throughout treatment. One safety behavior targeted in treatment was David’s seeking reassurances from the therapist. For example, when working on cognitive skills in session David would ask “is this label correct” or “am I doing this right?” and “I feel like I am wasting your time.” Therapist discussed this safety behavior with David among others he engages in. For example, when his professor provided them with presenting their project to the class or only to the professor in his office, David opted to present to the professor only. He reported this way he does not experience as much pressure when presenting. Therapist discussed the issue of avoidance and how it maintains our anxiety. Throughout treatment, David would report the anxiety he experiences when he confronts the situations or cognitions instead of avoiding, is “too much.” He reported that he believes he cannot handle it. Therapist discussed how this too is an automatic thought, and it is important to view thoughts as opinions and not facts. Therapist also discussed that the treatment for anxiety requires an investment in anxiety in order to have a calmer future or in other words, experiencing anxiety in the short term in order to help maintain the anxiety in the long term. The therapeutic relationship was actively fostered throughout treatment.

David presented for 12 sessions of therapy and only completed portions of the recommended treatment. David received psychoeducation about the three components of anxiety, the influence of thoughts on feelings and behaviors, objective self-monitoring of his mood and anxiety, cognitive restructuring training to challenge his thoughts, and relaxation training utilizing diaphragmatic breathing and progressive muscle relaxation. A hierarchy was not utilized in treatment due to David refusing to develop one with therapist in session. David reported that it was too stressful to even think about situations to add to the list. David refused to engage in imagery and in vivo exposure. He reported that, due to the stress of the end of the semester, he was not ready to engage in exposures. When asked if he would be interested in continuing therapy the following semester, David reported that he will not be returning to therapy.

Evaluation of treatment outcomes and disposition

David reported understanding the three components of anxiety helped provide him with a better idea about what he has been going through. David would go back and forth on how he perceived therapy. He had a pattern of disregarding the positive changes he experienced in therapy by attributing it to “luck” or a “one-time thing.” First, he reported that monitoring his thoughts was anxiety-provoking and overwhelming and that he does not think it helped him. However, he also repeatedly reported that labeling the thoughts was helpful making him more aware of the automatic thoughts he experiences and during session he would catch his thoughts and label them with the therapist. Second, David reported that PMR was not helpful and it made him more anxious. On the other hand, his progress chart from PMR shows a reduction in tension and anxiety. David also stated that adding weights when utilizing PMR helped him notice a difference in tension. David also reported that diaphragmatic breathing was challenging at first as

he attempted to hold his breath longer than what felt comfortable for him due to thinking that was the “correct” way to do so. After practicing diaphragmatic breathing at his own pace, he reported more success. A barrier for him was that he expressed anxiety implementing diaphragmatic breathing in public due to worrying others might see him. He expressed that others might think he was weird, and he is not comfortable expanding his stomach in front of others.

Throughout treatment David would repetitively state that his worry is what is helping him get through the stress of school and life which is also consistent with his diagnosis of GAD. He reported that he attributed his anxiety to school and that once he graduates his anxiety will subside, hence he believed that his anxiety was only because of stress in school. Although therapist explained that progress in treatment requires inducing anxiety to become calmer in the future, David reported that he did not like the anxiety he would experience from the techniques.

However, David benefitted from therapy in multiple ways. First, by the end of treatment, David better understood his anxiety and how it is maintained. David could provide multiple examples of avoidance behaviors he would engage in his life and acknowledged that these behaviors maintain his anxiety. Second, David, reported questioning his thoughts and being aware of his tension in relation to his anxiety. For example, David reported using his own disputing questions in session and outside of session. Although treatment was terminated prior to exploring David’s core beliefs, he reported that he came up with his own list of disputing questions that he felt comfortable with when questioning his automatic thoughts.

Evaluating Strengths and Areas for Therapist Self-Growth

Overall, therapist demonstrated strengths and weakness over the course of treatment. There are multiple areas of improvement and self -growth for the therapist after implementing

this treatment. Due to the client's severe anxiety, therapist could have started with relaxation techniques before introducing cognitive restructuring. When David began monitoring his thoughts, he reported feeling intense anxiety as if he were "experiencing" the thoughts, which he explained made it difficult for him to monitor and label his thoughts. Although therapist discussed the importance of monitoring thoughts and explored David's impression of this technique and troubleshooted barriers, it could have been more helpful to teach David relaxation techniques prior to cognitive therapy techniques. This may have helped David be able to monitor, label and challenge his thoughts successfully by lowering the distress he experiences when thinking about them.

Another area for improvement in therapy was that the therapist did not monitor David's attitude and confidence towards treatment throughout the sessions and this could have been addressed earlier. After multiple sessions, David reported that he believes as soon as he finishes school his anxiety will subside. He also believed that he will soon reach "midlife" and experience a midlife crisis in which he will not have a care in the world and will not experience anxiety as he does now. He phrased it as being a "phase that will pass". Although therapist addressed this in session, it would have been helpful to monitor David's attitude consistently. Therapist eventually discussed it in depth after a few sessions of noticing David refusing to work on techniques in treatment.

During the course of treatment, the therapist noticed patterns in David's behavior that were consistent with the diagnoses of obsessive-compulsive personality disorder. As discussed previously, this was a major barrier to treatment. Although therapist acknowledged this behavior pattern, therapist could have tailored treatment to also target rigidity and control in David. Therapist was not competent in this area of treatment and began to research evidenced based

treatments that can be used in conjunction with CBT. Specifically, therapist could have taken advantage of radically open dialectical behavior therapy (RO DBT). RO DBT has been shown to be applicable to disorders characterized by excessive inhibitory control and treatment resistant disorders of overcontrol (Lynch, Morse, Mendelson & Robins, 2003; Lynch & Cheavens, 2007). Since overcontrol, rigidity of thinking patterns and difficulty tolerating change or uncertainty are symptoms that David has displayed and are encompassed by OCPD, RO DBT has been shown to target these symptoms (Beck et al., 2015; Gallagher, South, & Oltmanns, 2003). RO DBT could have been utilized in treatment with David and treatment may have progressed more successfully and further than it did with only CBT as treatment.

Strengths of therapist include the ability to build a strong therapeutic alliance with David as evidenced by the client being comfortable enough to sit in a relaxed posture and engage fully in diaphragmatic breathing, sharing personal information that he reported being uncomfortable sharing in the beginning of treatment, and sharing his thoughts on paper with the therapist after reporting that he is not comfortable sharing any of his writing with anyone. Other strengths included the ability to help David recognize his cognitive distortions, label them and develop rational responses. This was accomplished despite difficulty and barriers that presented themselves throughout treatment, such as David's low confidence in treatment and his rigidity when it comes to learning techniques and applying them.

The transcript provided was the 6th treatment session and the second session discussing cognitive restructuring. This session specifically discussed using disputing questions to challenge automatic thoughts. During the session there were areas of strength from the therapist as well as areas for improvement. Therapist was able to provide responses that challenged David's rigid thoughts and beliefs about himself and his positive attitude towards his anxiety. For example,

therapist brought examples when David did not take breaks (as he believes taking breaks leads to failure) and did not fail. Therapist discussed how David did not care much about school when he was in high school and skipped class as well as did not study. However, he was still able to get into college and succeed. Therapist also successfully brought to David's attention his maladaptive pattern of taking breaks such that he would overwork himself which leads to taking long breaks which in turn makes it difficult for him to get back on track. Therapist emphasized that it is in fact being overworked that hinders his performance and not the break itself. Areas for improvement within this session, was for the therapist to come back to the agenda for the session. During session, therapist explored areas which could have been discussed later as to not miss teaching cognitive restructuring. Therapist could have taken advantage of discussing breaks and used it as an example to use in cognitive restructuring. Another aspect that therapist could keep in mind for improvement is time. This management session ended without getting to the point of cognitive restructuring and how the goal is to think differently and in ways that are more realistic and helpful. However, session ended without covering multiple items in the agenda.

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Appendix A

Consent Form

Washburn University Informed Consent for Case Study

This document contains important information for you to decide whether you are willing to give your permission to be involved in a case study led by a psychology graduate student therapist from Washburn University. Please read this document carefully, and feel free to ask any questions you might have.

Purpose of the Case Study

A case study is a detailed evaluation of therapy techniques your therapist will use to help you feel better over the next few weeks. The case study provides psychology graduate students at Washburn University the opportunity to practice and demonstrate clinical skills they have learned throughout their graduate training. As part of this process, the graduate student will research how to best help you based on recent scientific evidence. Psychology graduate students who choose to do this case study are supervised by licensed psychologists, who will evaluate the graduate student's skills.

Client's Understanding

- o I understand that the psychology graduate student is submitting this case study as partial fulfillment of the requirements for the Master of Arts degree at Washburn University.
- o I understand that the psychology graduate student's training involves recording and transcribing **a therapy** visit I have with him/her. The recording **will be destroyed** upon the graduate student's completion of the case study, but the transcription will remain part of the written project. The student will **protect my anonymity** such as changing my name and omitting family members' names, not using my birthdate, and not specifically referring to the clinic where I'm being seen for therapy.
- o I understand that the psychology graduate student is required by Washburn University to give a small talk to a group of mental health professionals that discusses the work I did with my therapist and/or have a summary of my experiences with my therapist printed in a professional journal without the use of my real name or other identifying information.
- o I understand that my information will be **shared in a de-identified manner** with [the internship site] and the panel of three clinical faculty members at Washburn University (see below) for supervision purposes.
- o I understand that my **participation is voluntary**, and that I may withdraw my participation. However, I understand that my de-identified information may still be used after my withdrawal in order for the graduate student to satisfy his/her training requirements (small talk or publication in a journal).
- o I am aware that **all records will be kept confidential** in the secure possession of [internship site].

- o I understand that I am able to contact the graduate student or any of the clinical psychology faculty (see below) if I should have any questions throughout this process.
- o I realize that I will be given a duplicate copy of this consent form.

My signature below means that I have read the document, it has been fully explained to me, I have asked any remaining questions, and I am freely giving my consent to participate in the case study.

Client Full Name: _____

Client Signature: _____ Date Signed: _____

Graduate Student:

Clinical Faculty Panel: Angela Duncan, PhD, Cynthia Turk, PhD, and Dave Provorse, PhD
Washburn University, Psychology Department
1700 SW College Ave, Topeka, KS 66621
(785) 670-1010

Appendix B
PSWQ

Please rate your answer according to how typical or characteristic each statement is of you.

	Not at all Typical				Very Typical
1. If I don't have enough time to do everything, I don't worry about it.	①	②	③	④	<input type="checkbox"/>
2. My worries overwhelm me.	①	②	③	④	<input type="checkbox"/>
3. I don't tend to worry about things.	①	②	③	④	<input type="checkbox"/>
4. Many situations make me worry.	①	②	③	④	<input type="checkbox"/>
5. I know I shouldn't worry about things, but I just can't help it.	①	②	③	④	<input type="checkbox"/>
6. When I am under pressure I worry a lot.	①	②	③	④	<input type="checkbox"/>
7. I am always worrying about something.	①	②	③	④	<input type="checkbox"/>
8. I find it easy to dismiss worrisome thoughts.	①	②	③	④	<input type="checkbox"/>
9. As soon as I finish one task I start to worry about everything else I have to do.	①	②	③	④	<input type="checkbox"/>
10. I never worry about anything.	①	②	③	④	<input type="checkbox"/>
11. When there is nothing more I can do about a concern, I don't worry about it any more.	①	②	③	④	<input type="checkbox"/>
12. I've been a worrier all my life.	①	②	③	④	<input type="checkbox"/>
13. I notice that I have been worrying about things.	①	②	③	④	<input type="checkbox"/>
14. Once I start worrying, I can't stop.	①	②	③	④	<input type="checkbox"/>
15. I worry all the time.	①	②	③	④	<input type="checkbox"/>
16. I worry about projects until they are all done.	①	②	③	④	<input type="checkbox"/>

Appendix C

Social Interaction Anxiety Scale

For each question, please indicate the degree to which you feel the statement is characteristic or true of you. The rating scale is as follows:

0 = Not at all characteristic or true of me

1 = Slightly characteristic or true of me

2 = Moderately characteristic or true of me

3 = Very characteristic or true of me

4 = Extremely characteristic or true of me

	Not at All	Slightly	Moder- ately	Very	Extremely
1. I get nervous if I have to speak with	①	②	③	④	⑤
2. I have difficulty making eye-contact with others.	①	②	③	④	⑤
3. I become tense if I have to talk about	①	②	③	④	⑤
4. I find it difficult mixing comfortably with	①	②	③	④	⑤
5. I find it easy to make friends of my own age.	①	②	③	④	⑤
6. I tense up if I meet an acquaintance in the street.	①	②	③	④	⑤
7. When mixing socially, I am uncomfortable.	①	②	③	④	⑤
8. I feel tense if I am alone with just one person.	①	②	③	④	⑤
9. I am at ease meeting people at parties, etc.	①	②	③	④	⑤
10. I have difficulty talking with other people.	①	②	③	④	⑤
11. I find it easy to think of things to talk about.	①	②	③	④	⑤
12. I worry about expressing myself in case I	①	②	③	④	⑤
13. I find it difficult to disagree with	①	②	③	④	⑤
14. I have difficulty talking to someone I'm attracted	①	②	③	④	⑤

- | | | | | |
|---|---|---|---|---|
| 15. I find myself worrying that I won't know what | ① | ② | ③ | ④ |
| 16. I am nervous mixing with people I don't know | ① | ② | ③ | ④ |
| 17. I feel I'll say something embarrassing when | ① | ② | ③ | ④ |
| 18. When mixing in a group, I find myself | ① | ② | ③ | ④ |
| 19. I am tense mixing in a group. | ① | ② | ③ | ④ |
| 20. I am unsure whether to greet someone I | ① | ② | ③ | ④ |

Appendix D

BDI

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! If several statements in the group seem to apply equally well, you may select more than one. **Be sure to read all the statements in each group before making your choice.**

- | | |
|--|---|
| <p>1 ① I do not feel sad.
 ① I feel sad.
 ② I am sad all the time and I can't snap out of it.
 ③ I am so sad or unhappy that I can't stand it.</p> <p>2 ① I am not particularly discouraged about the future.
 ① I feel discouraged about the future.
 ② I feel I have nothing to look forward to.
 ③ I feel that the future is hopeless and that things cannot improve.</p> <p>3 ① I do not feel like a failure.
 ① I feel that I have failed more than the average person.
 ② As I look back on my life, all I can see is a lot of failures.
 ③ I feel I am a complete failure as a person.</p> <p>4 ① I get as much satisfaction out of things as I used to.
 ① I don't enjoy things the way I used to.
 ② I don't get real satisfaction out of anything anymore.
 ③ I am dissatisfied or bored with everything.</p> <p>5 ① I don't feel particularly guilty.
 ① I feel guilty a good part of the time.
 ② I feel quite guilty most of the time.
 ③ I feel guilty all of the time.</p> | <p>6 ① I don't feel I am being punished.
 ① I feel I may be punished.
 ② I expect to be punished.
 ③ I feel I am being punished.</p> <p>7 ① I don't feel disappointed in myself.
 ① I am disappointed in myself.
 ② I am disgusted with myself.
 ③ I hate myself.</p> <p>8 ① I don't feel I am any worse than anybody else.
 ① I am critical of myself for my weaknesses or mistakes.
 ② I blame myself all the time for my faults.
 ③ I blame myself for everything bad that happens.</p> <p>9 ① I don't have any thoughts of killing myself.
 ① I have thoughts of killing myself, but I would not carry them out.
 ② I would like to kill myself.
 ③ I would kill myself if I had the chance.</p> <p>10 ① I don't cry any more than usual.
 ① I cry more now than I used to.
 ② I cry all the time now.
 ③ I used to be able to cry, but now I can't cry even though I want to.</p> <p>11 ① I am no more irritated now than I ever am.
 ① I get annoyed or irritated more easily than I used to.</p> |
|--|---|

- ② I feel irritated all the time now.
③ I don't get irritated at all by the things that used to irritate me.
- 12** ① I have not lost interest in other people.
① I am less interested in other people than I used to be.
② I have lost most of my interest in other people.
③ I have lost all of my interest in other people.
- 13** ① I make decisions about as well as I ever could.
① I put off making decisions more than I used to.
② I have greater difficulty in making decisions than before.
③ I can't make decisions at all anymore.
- 14** ① I don't feel I look any worse than I used to.
① I am worried that I am looking old or unattractive.
② I feel that there are permanent changes in my appearance that make me look unattractive.
③ I believe that I look ugly.
- 15** ① I can work about as well as before.
① It takes an extra effort to get started at doing something.
② I have to push myself very hard to do anything.
③ I can't do any work at all.
- 16** ① I can sleep as well as usual.
① I don't sleep as well as I used to.
② I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
③ I wake up several hours earlier than I used to and cannot get back to sleep.
- 17** ① I don't get more tired than usual.
① I get tired more easily than I used to.
② I get tired from doing almost anything.
③ I am too tired to do anything.
- 18** ① My appetite is no worse than usual.
① My appetite is not as good as it used to be.
② My appetite is much worse now.
③ I have no appetite at all anymore.
- 19** ① I haven't lost much weight, if any, lately.
① I have lost more than 5 pounds.
② I have lost more than 10 pounds.
③ I have lost more than 15 pounds.
I am purposely trying to lose weight by eating less
μ Yes μ No
- 20** ① I am no more worried about my health than usual.
① I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
② I am very worried about physical problems and its hard to think about much else.
③ I am so worried about my physical problems that I cannot think about anything else.
- 21** ① I have not noticed any recent change in my interest in sex.
① I am less interested in sex than I used to be.
② I am much less interested in sex now.
③ I have lost interest in sex completely

Appendix E

Anxiety Sensitivity Index (ASI)

The one answer that best represents the extent to which you agree with the item. If any of the items concern something that is not part of your experience (e.g., “It scares me when I feel shaky” for someone who has never trembled or had the “shakes”), answer on the basis of how you might feel *if you had* such an experience. Otherwise, answer all the items on the basis of your own experience.

	Very Little	A Little	Moderate	Much	Very Much
1. It is important to me not to appear nervous.	①	②	③	④	⑤
2. When I cannot keep my mind on a task, I worry that I might be going crazy.	①	②	③	④	⑤
3. It scares me when I feel “shaky” (trembling).	①	②	③	④	⑤
4. It scares me when I feel faint.	①	②	③	④	⑤
5. It is important to me to stay in control of my emotions.	①	②	③	④	⑤
6. It scares me when my heart beats rapidly.	①	②	③	④	⑤
7. It embarrasses me when my stomach growls.	①	②	③	④	⑤
8. It scares me when I am nauseous.	①	②	③	④	⑤
9. When I notice my heart is beating rapidly, I worry that I might have a heart attack.	①	②	③	④	⑤
10. It scares me when I become short of breath.	①	②	③	④	⑤
11. When my stomach is upset, I worry that I might be seriously ill.	①	②	③	④	⑤
12. It scares me when I am unable to keep my mind on a task.	①	②	③	④	⑤
13. Other people notice when I feel shaky.	①	②	③	④	⑤
14. Unusual body sensations scare me.	①	②	③	④	⑤
15. When I am nervous, I worry that I might be mentally ill.	①	②	③	④	⑤
16. It scares me when I am nervous.	①	②	③	④	⑤

Appendix F

S D S

INSTRUCTIONS: Select the answer that best describes your situation NOW.

1.

WORK

BECAUSE OF MY PROBLEMS, MY WORK IS IMPAIRED...

⑩	⑨	⑧	⑦	⑥	⑤	④	③	②	①	⑩
Not at All		Mildly		Moderately		Markedly				Very Severely (Cannot Work)

2.

SOCIAL LIFE/LEISURE ACTIVITIES

(with other people at parties, socializing, visiting, dating, outings, clubs, and entertaining)

BECAUSE OF MY PROBLEMS, MY SOCIAL LIFE/LEISURE IS IMPAIRED...

⑩	⑨	⑧	⑦	⑥	⑤	④	③	②	①	⑩
Not at All		Mildly		Moderately		Markedly				Very Severely (I never do these)

3.

FAMILY LIFE/HOME RESPONSIBILITIES

(For example, relating to family members, paying bills, managing home, shopping and cleaning.)

BECAUSE OF MY PROBLEMS, MY FAMILY LIFE/HOME RESPONSIBILITIES ARE IMPAIRED...

⑩	⑨	⑧	⑦	⑥	⑤	④	③	②	①	⑩
Not at All		Mildly		Moderately		Markedly				Very Severely (I never do these)

4.

WORK & SOCIAL DISABILITY SCALE

**Mark the item that best describes your disability.
PLEASE FILL IN ONE NUMBERED BUBBLE BETWEEN 1 AND 5**

<u>Score</u>	<u>Definition</u>
⑤	Symptoms radically change or prevent normal work or social activities.
④	Symptoms interfere with normal work or social activities markedly but they are not prevented or radically changed.
③	Symptoms interfere with normal work or social activities in minor ways.
②	Symptoms mild, but not interfering with normal work or social activities.
①	No complaints, normal activity.

Appendix H Transcription of session

Therapist: Hi David it is really good to see you again. Tell me about how your week has been.

Client: Yeah,um, it's just been really hard for me to remember the week.

Therapist: Hm, was it a stressful week?

Client: No,um, I just, I don't know I just tend to forget everything. Like if I am filling something out that will require me to remember how I felt on Monday (yesterday), I don't remember.

Therapist: Okay.

Client: I may remember that moment, but I don't always recall what I was stressed out about or anything like that. I guess because I feel like there is no reason to think about it.. It is just going to stress me out even more.

Therapist: So..so you feel like..

Client: So it would be best to move on.

Therapist: So you feel like, you know, going back and thinking about these automatic thoughts that you have in a previous situation, makes you stressed. So, you're just like " I don't want to remember them or think about them because they will make me anxious and stressed out."

Reflective listening; Paraphrasing, Empathy

Client: Well, it seems just repetitive of.., it's like I am torturing myself.

Therapist: Okay... (Pause).. So walk me through this (cognitive restructuring sheet), how was it doing this? ***Open-Ended Question***

Client: Uhm, I did the first half when I was tired and I got really irritable and angry at it.

Uhm..Because the questions (disputing questions) didn't go with it and I started asking myself what year was the book that these questions taken from who were they experimented on?was it male was it female? What age range? Were there certain..you know how was the experiment for these questions related to who? Was it a different culture? So, some of them just didn't work. Like the first one uhm. So you change it to a statement right?

Therapist: Right. ***Encourager***

Client: The statement is a lot more different than the question.

Therapist: Exactly, yeah.

Client: I'm not saying that it uhm..and I will not get this done on time.. so I wasn't saying that I wouldn't get it done on time I was saying "what would happen if I did not finish this on time?" and that's pretty much what pushes me to do it now, because I say to myself "while I know what's going to happen I'm not going to get a good grade for it" or whatever.

Therapist: Uhuh

Client: So to make myself stop doing that statement to myself, I would usually always say to myself "you're wasting energy beating yourself up when all you have to do is just do it just do it right now" and then you know, while I'm doing it I'm like oh my God I have a week and I have all this stuff scheduled to do throughout the week. So I just need to get it done now and then as soon as that's done I don't have that to worry about any more so I don't have that anxiety anymore.

Therapist: Yeah okay.. so like you mentioned uhm you know you're thinking about what would happen if I didn't get this done on time and so what is your fear of what will happen if you didn't get it done on time? ***Paraphrasing; Open-Ended Question * (cognitive restructuring/ pulling for intermediate beliefs)**

Client: Well it's just like a domino effect. It's you know, a lot of the first half of my life I wouldn't finish drawing. It drove me crazy but I still never did go finish it and even though it drove me crazy I didn't care about grades. It didn't matter to me. It just didn't matter to me. I didn't think uhm..I would even go to college. I didn't think I could afford it. I didn't think I was smart enough. So once I started it was like you know let me do something that I can finish. and so that was an important moment that played a big role in a lot of things.

Therapist: Uhuh. So like what? ***Encourager / Directive***

Client: Where you know like what it's like with weight loss. I will do it and never get myself a break and then when I do get that break, I just fall off the edge. And every time I've ever given myself a break, even if it's for a day or two it just all goes downhill. And it turns into something bigger.

Therapist: Mhmm.

Client: I realised when I give myself.. it's all or nothing when I give myself a break it's all downhill but there's no in between. And I can't find a medium or give myself a small break. There is like if I take a break I'm going to take a breaaaaak. It is going to be a big break. And then I am like aargh and it's like I'm going a hundred miles an hour to stopping instead of just slowing down or winding down. I can't seem to take small breaks because I feel like if I do I will be behind.

Therapist: Yeah that's a good point that you bring up there so like you mentioned before you didn't care much about breaks and you didn't think about that until you got to college. And even with that, you're here right now. Uhm.. even though when you were in school you didn't care as much about your grades and you didn't complete your work in school and thought that you

weren't going to be able to get into college, you still made it to college. ***Paraphrasing; Validating*** (Eliciting different perspective)

Client: Right..

Therapist: Right so you STILL got into college despite doing all of that. ***Complex Reflection (reframing)*** (Analyzing his automatic thoughts)

Client: Well when I found out that once I could get grants then it was then when I realized that I could, uhm, be able to go to college. So you know why not try then?

Therapist: Mhm right.. ***Encourager***

Client: And I didn't know what I was going to go for when I got to college that was another problem. So I started to see when something comes up and if something was interesting because I will learn different things and maybe it would help point me to the right direction then I would know what I wanted to do in college.

Therapist: Yeah..

Client: And yeah..

~Pause~

Therapist: So.. so yeah that's a really great point too. So like you mentioned with regards to taking breaks, when you do take a break it's like you know you have this belief that " if I take a break then everything goes downhill". ***Paraphrasing*** (Eliciting and Identifying intermediate beliefs)

Client: Well, it seems more than that. It is more that it WILL happen and not that it's a belief. It's because I know that it will happen because it happens every time I take a break.
could have discussed the belief further

Therapist: Hmm.. ok so walk me through a time that that happened. ***Directive***

Client: Uhm.. I don't know I mean a lot of times with weight loss. So it's just like I would go hardcore and like you get tired and you do stuff and then you're like you know what? I'm going to give myself a break.

Therapist: Mhmm.. ***Encourager***

Client: I'm going to drink an energy drink you know I don't do those anymore but why not I'll just drink one. Maybe I'll just need to celebrate with one. Then the next day it's like well you know it's only one. Then the next day it's like it's only one again.. It's like it's a drug or something that you can get addicted to. Then you just go downhill and you're like after a week your like well screw it.

Therapist: Mhmm.. ***Encourager***

Client: Uhm with Martial arts uhm..In my throat and here I was getting closer to my black belts and so I was going so hard core that I would practice every day every single lesson I would go to everything. To every lesson. And then I just got burned out. I was so tired and I hurt my foot at a tournament. It hurt just walking on it. So then I didn't go for a week and then it just.. I showed up maybe once or twice and then I felt out of shape all of a sudden. And uhm.. then I just stopped going.

Therapist: Mhmm. (nodding) ***Encourager***

Client: Even though uhm I still have like have years to still pay for it and I was really close to getting to the black belt, which is what I wanted to be and I didn't. And it was upsetting later on I wasn't going to go through all of that again. Uhm but it was upsetting even thinking about that. I didn't even finish this tournament.. I couldn't even reach to get where I wanted to get and also I didn't get to finish what I paid for. So uhm I game myself a break and so this is what happened.

Therapist: Mhmm (nodding) ***Encourager***

Client: So even with the weightloss things I ended up gaining around 250 lb and it I was like wow what happened?

Therapist: Okay.. okay so thanks for providing those examples for me. So you mentioned that the pattern that you're seeing with these examples is taking that break and.. ***Reflective listening; Reinforcing***

Client: And so for me.. In school what I would tell myself is I'll get a break..

Therapist: Yeah.. ***Encourager***

Client: When summer comes around that's my break.

Therapist: Okay.. and that is a long time that is a year!

Client: That's a long time..well I mean only a couple of months or something..

Therapist: Hmm so.. I mean looking from Fall to Summer

Client: No from May till August.. Fall break doesn't count.

Therapist: So you are telling yourself from now or from Fall my break will be in the summer.

Client: Yes.

Therapist: So you're telling me these examples and you know you mentioned that the pattern that you see is taking that break is what's making me go downhill.

Client: Right..

Therapist: So the pattern that I see there is “going hardcore and going so hard to the point that I can't take it anymore so I stop right? ***Reflective Listening***

Client: Right.

Therapist: Or not just that I can't take it anymore, but my BODY can't take it anymore. So I stop, which is you know a natural reaction for us to have. When we are exhausted we stop doing what is making us exhausted right and so maybe it's looking at it in a way of instead of not taking a break or excuse me instead of thinking of it as “I shouldn't take a break”. Thinking of it as “how can I do this a certain way so that I'm not burned out to the point where I don't have a choice but to take a long break extended break. So how can we, you know figure out a way to be effective and productive in the things that you do but to also provide yourself with that time to take a break. ***Psychoeducation; Additive Empathy***

Client: Yeah

Therapist: To where you do not find yourself in that cycle of being burned out because you did not take a break. Do you see the pattern that I am talking about?

Client: Oh yeah. And I have always wondered how to go medium and I can't, there is no medium. Things turn out so much better, my artwork turns out so much better if I put in a lot of effort. Everything that I try extremely hard in, works really great. If I don't put the same amount of effort, If I give medium effort, then it is not going to be the same, I am not going to learn the same thing..

Therapist: Have you tried that? ***Directive***

Client: I have.. I don't know. There, there's, there's no medium.. Because you just.. I can't you know, I can't half ass something. You know, especially if it means something to me. And if it is going to be shown to other people that can affect where I go in the future. You know, what kind of work does this person put out? How hard does this person work? How good are they with other people? And things like that. And it is really important. So do you want to work with somebody that doesn't really care about their work, someone that kind of cares, or someone that is driven, always there, always working hard? That is who I want to work with because they care about what they are doing. And when you are surrounded by people who care about what they are doing it actually brings the stress down. You don't feel like you are by yourself.

Therapist: And I agree with that. You know, going to that point where you are driven.. ***Complex Reflection (Agreeing with a twist)***

Client: but everybody is not like that.

Therapist: Everybody is not like that. But here's the thing, here's what I am hearing you say is if I, you know, give myself breaks or small breaks in between, uhm, then that means that I am not driven and I am not working hard enough. So, from what you are telling me if I don't go hardcore and give it my all without breaks, then I am not a hard worker. If I don't go hardcore to the point where I am burned out, and then I shut down, then I am not a hard worker. ***Complex Reflection (Amplified)*(Eliciting and identifying intermediate beliefs).**

Client: Well I don't want to get to that point where I am burned out and shut down.

Therapist: It sounds like that is where you are going.

Client: It is just.. It's like when you push the gas on your car, if the pedal sticks, the pedal is sticking all of the time. Uhm..

Therapist: Yeah..

Client: I mean I have had projects where I have not gone extremely hard and they just weren't, I was very unhappy with myself. It was not good.

Therapist: So what happened during that time? ***Directive***

Client: I knew I could do better.

Therapist: Okay. How did it turn out? ***Directive***

Client: I mean it was fine to the professor and everything.

Therapist: Okay.

Client: But it was not fine to me.

Therapist. Okay, so, what wasn't fine about it? ***Directive***

Client: I knew that I could have spent more time on it. And instead of working on it I was watching netflix. I was doing something that had nothing to do with it and it was not helping me further my skills or anything like that. And you know when I was doing it, it was like "oh I need this".

Therapist: Yeah! ***Encourager***

Client: You know, I need something like this. But it didn't help me.

Therapist: Okay. So, you have that recognition of " I need this break", and also, when you turned in the project, the professor said that it was good. Right? ***Reflective Listening***

Client: Right.

Therapist: You got a good grade on it. But internally, you felt like you could have done more. Now, let's say you didn't watch Netflix, let's say you didn't give yourself that break. Who's to say, that towards the end of it you won't be burned out and that maybe it could have turned out worse? ***Could have discussed thinking errors* *highlighting "disqualifying the positive". (Disputing his automatic thoughts).**

Client: I mean that hasn't happened so I can't believe that. I mean there are things that I know I can do to improve and you know I didn't. I mean there's times when a professor will say "hey why don't you add this and add this and add that" and I don't do it because I feel like that's way too much I mean I will be burned out at that point.

Therapist: Yeah. ***Encourager***

Client: So there are things that I don't go beyond certain points but you know it's expected of me not to turn in bad things or I mean bad things to me, for my skill level. Not compared to other people just to myself you know?

Therapist: Okay so..

Client: If you put out really, you know, stuff that has a lot of detail and a lot of work in it and all of a sudden you don't, you know, what happened for that to happen?

Therapist: So if you were to turn in something that was not to the best of your ability, what would happen? ***Directive; Open-Ended Questions***

Client: What do you mean?

Therapist: What do you fear will happen in that situation? ***Probing question***

Client: Just the embarrassment for the critique. Where they will tell me things that I know I could have done but I didn't because I was lazy about it you know? And it's just it sounds like failure. But even if they'd still give me a good grade, it's like the thing where you don't look at the positive but focus on the negative. It's that you know the teacher is telling me I got the highest grade in the class and I'm like okay but I got this wrong, how do I figure out the answer to this? That's all that matters because, you know, the degree does matter but also what matters is the grade in the end. That's just a sub goal to get to my goal so once that is in the book that's done. I don't even have to worry about it anymore so yeah. So at the end of the semester when I've got all A's, then I'll go to Red Lobster and eat something and be happy.

Therapist: Okay so it's great that you're saying I will celebrate my success and I will celebrate.. ***Validation***

Client: Yeah, in a sad lonely way hahaha.. By myself at red lobster.

Therapist: But you know it's interesting how you won't celebrate that and the assignment or getting that good grade on the presentation or that project. So what would happen if you did celebrate those little accomplishments? Because they are still accomplishments. ***Additive Empathy; Probing Question* (Process comment; Eliciting intermediate beliefs).**

Client: Sure.. well I mean, I'd be wasting my time doing that to get to my next goal so if I had an A on one assignment but none of the rest I'm not going to have that same outcome in the air so it's like just grit your teeth until you get through all of this to get the best outcome in the end

Therapist: So then looking at it this way where it's just like I'm doing this thing, going to school to get As and get my degree. And as soon as I'm done with that goal after that I get into the work place and I start to have other goals such as finishing a project at my job and moving forward with my career. ***Paraphrasing; Summarizing***

Client: Uhuh..

Therapist: So then having that same idea of “okay, I gotta get this done and move forward now”, how would you say that where you would be at in your life at that time and having that mentality where you're like “just go do it don't think about anything else”, what would your life look like? ***Open-Ended Question***

Client: Uhm. I dont know..

Therapist: So trying to figure out how we can shift that way of doing things to where you can also enjoy what you're doing, take time for yourself, right? ***Additive Empathy***

Client: Right..

Therapist: So it's finding that balance of getting the things that you need to get done and also giving yourself that time too. Because that time that you give yourself, for example like that time off that you took on Netflix was time to recharge. So if your battery is low even if you tried to get work done you may not be able to get much done or do much better than what you already have. But, if you give yourself that time to watch Netflix and take that break, you may be able to come back to doing that work and doing the best that you can. (Pause) ***Additive Empathy***

Therapist: So what are your thoughts on that? ***Open-Ended Questions***

Client: It just depends on what it is really. And it, uhm, depends if I'm tired or not. So for instance this right here, the first two questions or the first three questions, I was just really tired. I just started questioning all those things like “what methods were used?” and “who were these questions done on?” “what were their age?” and all that, because it didn't work with what I was saying to myself in my head for those. So these questions don't work with it because it's like I felt like I would do better by making my own questions.

Therapist: Okay. ***Encourager***

Client: Which is what I do when those things come into my head. I do question those thoughts, but I use my own questions. I usually do answer them in a way and then that's what makes me get it done. Because I'm like well if you do this then you won't have the same anxiety and that's what kind of pushes me to get things done

Therapist: Okay so that's.. that's really great that you bring that up actually, because that sheet that I gave you was basically just to kind of give you an idea of how it works. So those aren't the only questions you could ever use it's just used to start off with how we can question our thoughts. So you mention that you have your own questions which, is great because that's the goal in the end. It's to basically do this on your own and figure out what works for you. So you don't have to stick to that sheet or those questions. This is just giving you an idea of some examples of ways to think of these differently. Right, so why don't you walk me through this then. I really want to see the process of how you get to this and how you came up with that rational response. So walk me through this step by step. ***Reinforcement; Open-ended Question; Directive; Psychoeducation***

Client: Okay so like... (long pause) so should we start with the first one?

Therapist: Sure. ***Encourager***

Client: Uhhh (long pause). Okay so most of them did not help me think differently.

Therapist: Okay so then let's just go over the ones that did help first, and then we can go back to the others. ***Directive***

Client: Uhm..probably this one.

Therapist: Okay so the first one is "I don't have enough anxiety to be here",

Client: Yeah..

Therapist: Okay.

Client: So I chose to label it as All or Nothing.

Therapist: Okay, great! ***Validation***

Client: So I said "what does "I don't have enough anxiety mean?"" It means I am below the threshold for anxiety which means that I'm wasting her time.

Therapist: Okay..

Client: So does not having enough anxiety really mean that I am...uhm so there's two different ones

Therapist: That's okay..

Client: That I'm an imposter and.. (Pause)

Therapist: That you are not anxious enough to be here? ***Simple Reflection (rephrase)***

Client: Yeah

Therapist: Okay..

Client: And so I said no it means that I'm trying to learn so that I can keep my anxiety under control in the future. So in turn allowing me to work harder, to love my job and not to have a heart attack over it.

Therapist: Okay great! So you are here because you want to live a life where anxiety is not controlling you and you uhm want to learn skills that will help you manage your anxiety.

Validation; Simple Reflection (Rephrase); Encourager

Client: Yeah..

Therapist: Okay yeah so tell me how that makes you feel when you went through this process? Questioning your thoughts and then coming up with rational statements. ***Probing question***

Client: Well I mean I don't really know. I mean I don't really think that they really changed how I think. I already questioned it you know that's why I'm here basically (long pause)...I mean I guess I could have went with this one. Where you know I think that I was thinking that, you know, maybe you guys may have had like an emergency person that came in, you know, you had a student or person that would have a bigger need to be here so like that lady that was here the first time so it was like uhm...

Therapist: Tell me more about that.. ***Directive***

Client: Like, I'm taking up space or the time where someone could, you know cover someone who needs serious help. Someone can come in and want to be seen and I would be taking up that time.

Therapist: So you're saying that you being here is taking up a time where someone else could have, because they need more help than you? ***Simple reflection (Rephrase)* (Eliciting automatic thought)**

Client: Yeah.. because they might be suicidal or something like that.

Therapist: Okay and so that's what makes you have that thought of "I'm just wasting her time".

Client: Yeah..

Therapist: Uhuh so..

Client: And just like I'm not to the point where I have to be here but I'm here so I don't get to that point and I'm wasting your time because of that.

Therapist: Okay wow. So walk me through how you challenged that thought. ***Empathy; Directive***

Client: Okay so I then said that people schedule things and if there is an emergency there are ways to get help and so that's what I had.

Therapist: That's true that's exactly it! And not just that people are able to schedule appointments as well as stop by but let's add on another thing there too which is that everybody is at a certain level with where they are at with regards to needing help or coming to therapy. So there is a good reason that you're here. You're wanting to learn skills and tools to be able to move on with your life and to not let that anxiety control you and so that's a legitimate reason to be coming to therapy and getting help for. And that's what we're here for too. So, we are not just here to help individuals who are suicidal or have an emergency but we are also here to help individuals with whatever goals they have when coming to therapy.

Client: Yeah so my goal is to be able to control my thoughts when I get to that point because I will eventually get to that point sometime..

Therapist: Hmm so here's the thing. You mentioned a really important point there which is wanting to control your thoughts. With that, one thing that we know is we can't control our thoughts but we..

Client: Right.. I mean like more as being able to recognize those, my thoughts and myself

Therapist: Yeah yeah exactly. We can't control our thoughts but what we can do is recognize them and challenge them.

Client: So like I mentioned a while back when I had that moment of clarity about my life and I was like "you know it's okay because it's not the end of the world". So I wish to recognize those things and have those moments more often and that would not only help me but it would also help other people too. Or maybe I could put something in the words to help them to where they reach that same boat.

Therapist: That is very insightful of you! You are certainly in the right direction to where you want to be able to say to your anxious thoughts "you know it is not the end of the world" and help yourself have more moments like that. It was definitely difficult at first. You mentioned that recognizing those thoughts was anxiety provoking and exhausting for you and uhm that you felt like doing this process was too much. ***Validation; Positive feedback; Empathy; Paraphrasing***

Client: Yeah

Therapist: So after getting practice in session a few times, I appreciate you completing this especially after having a stressful week. You mentioned those first few were hard for you to complete. ***Validation; Positive Feedback***

Client: Yeah

Therapist: And that's Okay. So just recognizing that this is a new skill that you learned. And in the beginning, you know, it's really difficult and maybe a little time-consuming to get used to doing this. And so right now, you know, after trying this out in the previous sessions and doing this at home this week, how was this for you compared to when you first did it the first time? ***Psychoeducation; Open-Ended Question***

Client: Uhm.. I don't know.

Therapist: Have you noticed a difference?

Client: No not really.. Or what do you mean different?

Therapist: So like at first when we first Introduce labeling the thoughts it felt different for you and you mentioned that it was difficult for you and so he went through it together and session previously answer now I'll let you try it out on your own so how was your experience now labeling those thoughts and getting through this process before when he did it for the first time

Client: (Long pause) Uhm.. I don't know I mean I knew that I was, you know, I just I knew that I was saying stuff to myself that wasn't helpful, I just didn't put a name to it. I don't feel anything really.. I don't feel any different.

Therapist: Okay so you feel like questioning the thoughts is..

Client: I looked at it and it was like "okay well, it's not the same level that I'm doing it with those things that are going on. I have already answered those questions in my head without going through it. So I've been doing it but doing it this way has just been frustrating me..

Therapist: Okay so, you're mentioning that you already do this process in the moment when you experienced those thoughts

Client: Yeah

Therapist: So tell me about that process. When you did all of this cognitive restructuring in the moment in your head when something is happening, how's that for you?

Client: It was just an argument in my head.

Therapist: Okay..

Client: Usually when I have a bad thought, I tell myself “realize what you're doing right now, you need to stop arguing with yourself and just get started on your work. You know that once you get started, you're inside anxiety level will go down. Then you will be halfway through and then once you're done you can go get it checked. And then once it's done it's a lot less pressure and a lot less stress. And so then you can send it in and get a check for grammar and stuff like that. And you won't have to worry about it anymore “

Therapist: So you're kind of talking yourself through whatever it is that you're anxious about and telling yourself that it's going to be okay and that you can take certain steps to reach your goal. That then, made you feel less anxious and it was helpful for you. The other thing with that is though, the automatic thoughts that you have, they still haven't been challenged. So maybe going through these automatic thoughts on that sheet felt like “okay well I'm not going through this right now and I'm not even thinking them right now and so working through them and looking at them is just making me feel frustrated and really anxious and I just don't want to go through this process”. I don't want to think about them right now or look at them, when the moment comes I will think about them”

Client: Right

Therapist: But these thoughts that you have come up repetitively. With the time I have spent with you, these are thoughts that you consistently have. So like you mentioned just looking at these thoughts, and you're not thinking them in the moment, are making you anxious. So imagine when you are having these thoughts in the moment and you experience that anxiety...

Client: Well it's not just the thought it's everything that goes with it, all of this, like the questioning. It's because they didn't always work so it's really frustrating..

Therapist: Okay so maybe now it's just figuring out what questions work for you because like you said before, there were questions that you had in your mind that you felt were more helpful for you right? ***Reflective Listening* (Therapist made this statement to bring the conversation back to the agenda of cognitive restructuring)**

Client: Yeah I mean it's like I already knew the answers to most of these and even after questioning it and going through this process, I still felt like I was worried about it because I don't know the future. You know what if I break my arm, and then I have to spend all of my time at the hospital, so these are things that are going through my head and I am imagining these things. I imagine myself breaking my arm, then I see myself in the hospital, then I try to ask for internet access so I can get to D2L to get to my work so I can finish it before the next day. You know sure the professor may be like “sure I can give you pass so you can finish this whenever” you know, but no I don't want a pass I want to finish it so, because I don't want to things to be building up with homework. So I am imagining all of that stuff in my head. So it is not symbolic at all or just words it is all visual things happening in my head.

Therapist: Okay.. ***Encourager***

Client: So what did you ask? Hahaha Sorry..

Therapist: So, um.. What I am hearing you say..is fearing that lack of control of what is going to happen. ***Simple Reflection (rephrase)***

Client: Right. So it's like get it done while you know nothing bad is happening before something bad is going to happen before knowing when something will be effected like you car breaks down or something.

Therapist: So, it sounds like you are always on edge about being not just on time, but extra early in case something happens..

Client: Right.

Therapist: And..

Client: And then I won't have to worry when something happens. Which has happened.. I can't recall, but I know it has happened before, which is why it has led to me doing this. You know stuck behind a tractor, going through all of these hills, you can't pass nobody, and you are like 15 minutes late than usual. And it is okay because you have this huge buffer zone between you and what you need to get done. It is the same with my homework. Like I go to these lab time that are later at night because I am getting those done, I have all of this stuff pretty much done. Which gives me two extra days to do other assignments that I have been putting behind with independent studies. So now I have more time to work on that. So the time that I used to get stuff done now, has allowed me more breathing space to get other things done.

Therapist: It is interesting that you bring up the breathing space to get other things done. So it is more like get things done, so I can get the next thing done and the I can get the next thing done. ***Paraphrasing***

Client: The stress would be worse if I didn't do that. So instead of having it like this.. It would be like this all of the time. And this has been going on since I started school.

Therapist: Okay so has there ever been a time when you didn't finish something early enough?

Client: Uhm..no.

Therapist: Okay, so when you had something that needed to be done, it was always done as early as you can possibly get it done.

Client: Yeah. The goal is to get it done before it is due, but not the day of. Because then you are just rushing it. When I read through the chapter.. Everyone else usually takes half an hour, whereas I will take an hour to an hour and a half. I will spend 6-7 hours working on a paper in one day and continue to work on it the next day as well, where someone else took less than an hour to do it. I want to do good and I want to make sure I know what I am talking about. A lot of people will say " I just BSed my way through it.. And I am just like, what did you learn? Was there anything new you learned? I think that is an important part of me pushing so hard in school

, it is not just to prove that I am able to do it but to also come out as learning something new. For me to view multiple areas in my life differently with this knowledge. And I can tell a major difference in where I am now than where I started. I thought I was too stupid to even come to college. Now I know, I mean I don't know if I am smart, but I am not too stupid to not be able to go to college. (laughing) I know I am not good or perfect in a lot of things but I am better than I was. And I attribute that to the importance of the work and effort that I put.

Therapist: Yeah and that is great that you are able to acknowledge that. You value hard work and learning. Your goal is to learn. ***Complex Reflection (reframing)***

Client: Even if I don't use anything after school.

Therapist: Okay.. so you are wanting to get through it to learn as much as you can

Client: To prove to myself and yeah to have something. To come out and you know you are talking to somebody and they say something like "oh you seem like an educated person" sounds a lot better than .well I don't know whatever else is there I guess like a "he seems like a normal person maybe" (laughing) I don't know. But yeah it felt really good when people have said stuff like uhm. A lot of people like.. Uhm I joined this community thing it fraternal order of eagles where they help the community.. By doing fundraiser and things like that. So, I joined that to get more involved with the city and what was going on with the community. And I talked to a lot of people about my thoughts about their work. And a lot of people would say you know, "you are a smart kid, we need to get you on to the board and all of these things. And that felt really good. Because I was thinking about things more deeply more than just on area you know. That was really important to me, feeling like that. Some people didn't like me because of it but those were people that were like just bar fighters and were mean and treated women like trash. They would look at me and would be like, you know, what are you gay or something? Because, you know, this woman is hitting on you. And I just don't want anything to do with anybody because, I've got other things to worry about. I don't want to be in a relationship. So them looking at me in that way because of that was upsetting. But, does it matter what they thought? No. But it got to the point where some of those people that were doing that were just spreading rumors saying that I was gay. And it was all because I don't do the things that they do like treating women like crap and it was just really upsetting.

Therapist: Yeah that is upsetting. It is hurtful when people make rumors about you and say things that are not true. ***Empathy; Complex Reflection (shifting focus)***

Client: Yeah. The people that do that were just, they lived in that small town all of their lives, they drink every night, they do drugs. And I am still no different than they are , I was there as some point. But I moved on because I noticed the importance of things and they don't like that. They don't like me so they do whatever they can to put me down. So I would go to other places and the rumors were everywhere. Then I stopped going places there anymore.

Therapist: Okay.. so this occurred when you moved from _____

Client: Yes. This is when I moved in with my parents, and I wanted to get to know the community and I got more involved and then this happens. But now I don't see anybody there and I don't go out. I just don't need to be around these people.

Therapist: Okay..

Client: I mean you get lonely and you want to talk to people and then something like that happens and you are like, are you kidding me?! Why?

Therapist: Yeah.. so there's isolating yourself, feeling lonely, to avoid hearing the rumors from people..

Client: Yeah. and it doesn't help when the women that are hitting on you look like they are heroin addicts and they are just not going in the right direction and I get looked at because I am gay..like mmmm yeah..

Therapist: Yeah.

Client: I mean what do you do in that situation?

Therapist: You certainly have every right to say no and to not want to be involved in something you are not interested in, in this case it is that woman. ***Validation***

Client: I don't want to go down that road again..

Therapist: What road is that?

Client: Being in a relationship.

Therapist: Okay. You also mentioned feeling lonely too because of the isolation and feeling like "I don't want to talk to anyone and I don't want to deal with anyone". Has there been a time when you have had those connections with other people who did not spread those rumors?
Complex Reflection

Client: Yes! Usually with people about 70 years old..

Therapist: Okay.. in that same town?

Client: Yeah in the same town. They go to the same place that the others do so I would go earlier in the day when only the older people were there. Then when it is night time I would leave because I don't want to be around those people. People push buttons and want to start fights. My hands are registered as weapons (because of martial arts) and I could get jail time if I am involved in a fight. Then I started going to a different town, about 15 minutes away just to see people. And it was nice I was able to talk to people I don't know. But I can't do that all of the time.

Therapist: Yeah so you are seeking out those interactions with other people it is just not always readily available in the town. Would you say that every single person in the town you are at is that way? ***Complex Reflection (amplified)***

Client: I would say... (pause).. I mean yeah. The one's who are not are dying as they are all much older.

Therapist: So are you saying that all of the young people or people closer to your age are that way? ***Complex Reflection (amplified)***

Client: Huh uhmm .. all but one

Therapist: Who is that one

Client: Uhm she is a person that has uhm lived across the street for a little while and uhm she just moved.

Therapist: Ok and that is the only person?

Client: Yeah..

Therapist: So you are saying that there is not one young person in your area that you are able to connect with. ***Complex Reflection (amplified)***

Client: In this small town, there are only two places to go. One place you have to be a member of which I stopped being a member after coming here, and the other one is where some of those people that do those things are friends with people at that place and so they all talk. So the bartenders and everyone talk. I used to be more involved but I stopped after all of that happened.

Therapist: When you were involved, were there people that were good to you?

Client: Yes.

Therapist: What about those people? **(Eliciting different perspective)**

Client: I can't go hang out with them because they are like 70, 80 years old.

Therapist: You mentioned in the beginning that one of your goals was to connect with people and not be isolated..

Client: Well, everything that happened in that town is stuck to that town. It does not carry over to other places.

Therapist: So you do not experience that here. You feel like you are okay meeting new people, talking to people..

Client: I mean I'll talk to people but I still, it's just with women I am pretty much not comfortable with. Because I don't know what they think of me. If I you know, someone says "oh you are flirting with so and so.." not here but in that town.. I would think I was just being friendly I was just chatting. What I've got from it is having a conversation with someone, making eye contact and smiling is considered flirting with somebody. You can tell going up there by the way all of the guys act, you know I hate to stereotype it but, having the country dialect, and "let's not show emotions, let's beat people up" that's what they are like.. Almost everyone there is like that. And if you are not like that then you are gay.

Therapist: Yeah. And you know yourself and how you interact with other people which is different from how they interact with others. The people in that town are different in terms of how they live their lives. So what about here. Say a girl approaches you and you talk with here. Say you were being nice and they thought you are flirting but you were not. What would happen? **(Eliciting automatic thoughts)**

Client: I don't know..a lot of people here are married and have a boyfriend so I don't have to worry about it.

Therapist: Okay say they are

Client: And plus I am 37 so...

Therapist: Say it was a single person close to your age, that you are talking to. Just asking about how their day is, making small talk. And say, during the conversation, they think you are flirting with them. What would happen? **(Eliciting automatic thoughts)**

Client: I don't know..

Therapist: What would you do?

Client: Just go along. I would talk to them to finish the conversation.

Therapist: Okay, what about that barrier you discussed with women here. You stated that it was because you did not want to be misperceived.

Client: Uhhmm.. I hadn't had that problem here so... Usually when that happened it was when I was at a bar and the bartender would approach me and she would say "hey I heard you were flirting with that girl"

Therapist: During that time what was going through your mind? **(Eliciting automatic thoughts)**

Client: It was upsetting, that just being nice to somebody is considered flirting.

Therapist: And how did your behavior change after that? **(Question to help the client to understand the link between thoughts and behaviors)**

Client: I don't ever approach anybody. If they ever want to talk to me they can approach me. And I guess that does affect me here a little bit. Because if I go somewhere I don't approach anybody ever soo..uhm unless I drink something and then in that case I uhm approach.. If there is one woman or women then I don't. But if there are people then I would say hey you want to play pool. Or if there is someone next to me I might have a casual conversation with them. But not if it was a woman.

Therapist: Okay so what would happen if you did approach a group of women or a group of people? **(Eliciting automatic thoughts)**

Client: I don't know..I steer clear from that because.. I guess going back to that "I don't want them to ask me questions about myself". So I just don't.

Therapist: Okay this gives me a clear idea of some of the thoughts that you have and some of the behaviors you engage in that are a result of those thoughts. We went through the process of cognitive restructuring and you mentioned that it was difficult to catch those thoughts. Just from session today there were a couple of thoughts that we discussed such as "If I speak to women, they will think I am flirting with them", "If I approach people, they will judge me". What do you think about those? ***Positive Feedback; Open-ended Question* (Helping the client recognize his own automatic thoughts).**

Client: I mean it was mainly being upset about them viewing people being friendly. That is where their beliefs lie. It's like is everyone an asshole in this sit me? Is this what people expect? And this is why people are looking at me in that way? That is upsetting. So I am just like I just want to get out of here.

Therapist: Okay and if you were to get out of that town do you think you will continue to not approach people?

Client: I think I won't be as open anymore.

Therapist: So it is really impacting you a lot. ***Simple Reflection* (Help client to understand the link between thoughts and behaviors)**

Client: Yeah..

Therapist: So that situation happened at the bar, which lead to you avoiding going to places and talking with others, eventually leading to isolation and loneliness. It then started impacting you at other places that are away from the town. Right now we start by being aware of the thoughts that you have about these situations and challenging them like we did those other thoughts. ***Validation; Complex Reflection***

Client: Well, I feel like if I were to move away to another town I would be more open.

Therapist: Okay, so next time we will continue doing cognitive restructuring on those thoughts as well as introducing diaphragmatic breathing. I know you mentioned before that you

previously tried diaphragmatic breathing and you felt like it did not work or did not help. But I do want us to try that again and to find a pace that works for you. Another thing I want to bring up is you mentioning that part of you feeling tense and holding your stomach in even in session. Part of diaphragmatic breathing is being able to breath in and expanding your stomach. Is that something you can do next time I see you?

Client:(laughing) well right now I am comfortable doing that with you. Plus I wear sweaters now which makes it easier to not suck my stomach in.

Therapist: Okay great! Because we will be doing it together and I will walk you through it so I want to make sure we practice so you can get the hang of it and practice at home.

Client: Okay.

Therapist: Okay so this is a list of thoughts I had typed up from our previous sessions with instructions for the steps of cognitive restructuring. This is for you to work on during this week to get practice on labeling and challenging the thoughts. This time though, I want you to use questions that you are comfortable using when challenging the thoughts, whether they are your own or from that sheet. Because I really want to tailor this to what works best for you.

Client: Alright.

Therapist: Okay, what questions do you have? ***Open-Ended Question***

Client: There is one thing that comes up when I am starting to get worried and anxious. Like there is one that is coming up right now. My age and how I am thinking about a lot of things it's like.. It's sort of , I don't know how you'd call it, where older people just don't care anymore or care less than they used to and so just live their lives. So I just think, you know I am 37 when am I going to reach that point? For me I think a lot of this is that I think too much about things that are going to affect me and that I am too old to be like that. And, yeah I feel like that. So, that is another reason that I don't open up or talk to people about my problems or anything.

Therapist: Yeah ok. So you bring up a great point. You are wanting to reach that level where your anxiety is not controlling you anymore. What you have tried in the past has clearly not gotten you there and so you are here now to get there. Now it is not going to easily come to you. But being here learning these skills will give you the tools you need to get to that point. Where you can say "my thoughts do not control me anymore", "my anxiety does not control me anymore". It is hard at first, and it is anxiety provoking but it is a process. And in the long run it is what will help you manage your anxiety. ***Validation, Psychoeducation, Directive***

Client: Okay.

Therapist: Okay, what other questions or thoughts do you have?

Client: uhm nothing.

Therapist: Okay, let's look at the schedule to make an appointment for next week.

Client: Okay can we do the same day/time?

Therapist: Let me see if there is an opening. Yes sure!

Client: Okay.

Therapist: Okay it was great to see you today and I look forward to seeing you next week!

Client: See you next week.